HEALTH SAVINGS ACCOUNTS (HSAs) AND CONSUMER DRIVEN HEALTH CARE: COST CONTAINMENT OR COST SHIFT?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MAY 14, 2008

Serial No. 110–84

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
50–037 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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HEALTH SAVINGS ACCOUNTS (HSAs) AND CONSUMER DRIVEN HEALTH CARE: COST CONTAINMENT OR COST SHIFT?

WEDNESDAY, MAY 14, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:30 a.m., in Room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 07, 2008
HL–25

CONTACT: (202) 225–3943

Stark Announces Hearing on Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost Shift?

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on Health Savings Accounts (HSAs) and so-called Consumer Driven Health Care (CDHC) or high-deductible health plans (HDHPs). **The hearing will take place at 10:30 a.m. on Wednesday, May 14, 2008, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Medicare Modernization Act of 2003 (MMA) (P.L. 108–173) created new tax-preferred Health Savings Accounts (HSAs) to encourage adoption of high-deductible health plans (HDHPs). These accounts allow individuals and/or their employers to make tax-preferred contributions toward qualified medical expenses, provided they have HDHPs with deductibles of at least $1,100 for individuals and $2,200 for families for 2008. HSA holders can contribute more to the savings account (up to a specified limit) than would be required to fulfill their annual deductible, and any unused portions of the account accrue tax-free and can be withdrawn tax-free so long as the funds are used only for qualified medical expenses. However, unlike employer-provided Flexible Spending Accounts (FSAs), individuals are not required to prove or otherwise substantiate that their HSA withdrawals are being used for health care purposes.

As employers attempt to limit their health costs, some are turning to HDHPs—often called "consumer driven" health care plans—which have high-deductibles, often in exchange for lower premiums. While HDHPs have grown in recent years, only a fraction of those with these plans have active HSAs. These plans shift the cost of health care away from insurers and employers and toward individuals. These plans are predicated on the assumption that consumers will make more rational health care choices if they have a significant financial stake in the cost of their care. Proponents of these plans argue that they will help control overall health spending. But these plans may discourage consumers from seeking treatment and obtaining preventive care, and total health spending could even increase if people defer or delay needed preventive care or initial treatment. These plans result in significant out-of-pocket costs for those with serious medical conditions. A June 2007 Kaiser Family Foundation study found that pregnant women could face high out-of-pocket costs under these plans, particularly when complications arise. Furthermore, an April 2008 GAO study found that the average HSA enrollees had incomes nearly three times the average income of other tax filers and that HSA contributions were almost twice that of withdrawals. Simply stated, these policies are designed to help those who can afford to put money away to do so, but only serve to put health care further out of reach for those with high medical costs and/or modest incomes.

In announcing the hearing, Chairman Stark said, **"HSAs and high deductible plans are a flawed policy approach to making health care more affordable. They make things worse, not better. Instead of using the Tax Code to encourage people to purchase coverage that may be woefully inadequate, we should focus on providing comprehensive health care coverage to those most in need in the most cost-efficient way possible."**

FOCUS OF THE HEARING:

The hearing will focus on HSAs and high deductible health plans.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Follow the online instructions, completing all informational forms and clicking "submit." Attach your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, May 28, 2008**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. Good morning, and we will begin our hearing on health savings accounts and high-deductible health plans.

In the context of health reform, some people have suggested that consumer-driven plans, which is a soft, fuzzy term for cost-shifting to patients, offer an effective or even an efficient option to expand coverage to the uninsured and to beef up existing coverage. I think that nothing could be further from the truth.

While these plans currently affect a small percentage of those with insurance, the ideology behind it seems to be what motivates some of our friends and the implications of widespread adoption of these plans I think is cause for alarm for all of us. MMA encouraged the adoption of high-deductible plans by creating health savings accounts, HSAs, that permit unprecedented tax-free savings for health care if one enrolls in a qualified plan.

The GAO will confirm for us that these HSAs are disproportionately used by high-income people and GAO's previous research suggested these plans attract healthier people than average. The selection of healthy, wealthy people, if these plans were widely adopted, could lead to a devastating cost increase for all who decided to remain in conventional insurance. It seems to me it's a waste of resources to forego revenue to advance that goal. We need to focus on measures that will help decrease cost and increase access, not the reverse.

The term "consumer-driven" or high-deductible plans are yet another instance in which the conservative rhetoric doesn't match the reality. These plans simply shift costs and responsibilities to consumers. Control may sound good generically, but health care is one area where no one is ever clearly in control. Some argue that consumers will make better decisions if they have more skin in the game, but health care is not a rational economic market. It's not and never will be like buying an automobile.

People often make health care decisions when they're sick, in pain, confused, and at their most vulnerable time. Consumer's Union, which publishes consumers reports has submitted written testimony to that effect. High deductible plans, especially in the non-group market, often exclude basic benefits.

In my friend Mr. Camp's district we could not find an HSA-qualified plan that covered maternity care out of over 30 plans that we reviewed. In my own district, only four plans would cover maternity benefits, and even if you paid for them out of your pocket, it wouldn't use that as working toward your deductible.

While HSA eligible, high-deductible plans may exclude preventive benefits from the deductible, most don't. And while some employers may contribute to the accounts, most don't. Even Mr. Sensor's organization, the witness invited to champion this model, only contributes 100 bucks to the health savings account. That's information separately provided to the Committee and not in today's testimony. And that's probably why few of their employees have taken up that option.

Most of his employees in the HRA-affiliated plan, where they essentially got full coverage and no copayment at all, given the employer contribution, there appears to be no risk or potential loss for the employee and no risk for the employer since they retain the unspent funds in the account. And, as I say, I have no objection to employers self-insuring for the copayment or at-risk portions if

they decided to provide first-dollar payment to their employees, which I think is a good idea.

The good things Alegent does in terms of disease management can and should be done in conventional plans as well, but simply shifting cost to patients isn't going to result in overall savings. It certainly doesn't encourage people to get needed preventive care and it will discourage lower and middle income people from seeking care when they need it. It seems penny-wise and pound-foolish.

If these plans were widely adopted, they might increase costs to our health care system, not to mention increase the uninsured while eroding the level of coverage among those fortunate enough to have insurance today. We must not be distracted from our goal, and that is to ensure guaranteed quality, affordable health care for everyone.

I want to note that we may hear a lot of talk today about how important it is to have better information, and I agree. But that's a red herring used to advance any policy, including this policy, which we're going to discuss today which we feel is destructive.

We get good information and put it in the right hands at the right time, but that's a separate topic for another day.

Chairman STARK. Mr. Camp, would you like to comment?

Mr. CAMP. Well, thank you, Mr. Chairman.

Now, for the rest of the story. You know, the Subcommittee's timing is impeccable since we have a new report that highlighted that now, 6.1 million Americans are covered by high deductible health plans and in accompanying HSA. The greatest growth in HSA enrollment is now in the small group market where HSA enrollment is increased 72 percent over 2007.

This growth is especially important because these are the same sorts of employers who are dropping their health insurance coverage because of rapidly increasing costs. For many small businesses, the affordability of HSAs has enabled them to offer health insurance coverage to their employees for the first time. The lower costs associated with HSAs have also enabled many small businesses to use those savings to invest in their employee's HSA accounts.

Martha Gallenger, who owns Corporate Building Services in Olathe, Kansas, wrote, and I quote: "We started an HSA plan in August of 2004. It has lowered our annual cost of insurance by 42 percent, even with my putting $600 per year in each employee's health savings account."

Mr. Wayne Sensor, who is the CEO of Alegent Health System in Omaha, Nebraska will testify of their costs of decrease by 15 percent, since they began offering consumer-driven health plans to their employees. These savings have also allowed Alegent to deposit extra money into all participating employees' HSAs.

Frankly, I was surprised to see how the GAO report is being cited to make sweeping conclusions about HSA being a tax shelter for those with high incomes. The report relies on data from 2005, when there was a mere 1 million people enrolled in HSAs. Today, there are more than 6 million people in HSA qualifying plans. So, again, before this Subcommittee, we have the GAO using incomplete data to draw an erroneous, sweeping conclusion.

And, frankly, I want some answers as to why this is continually happening and again I am going to send a letter to the acting controller and try to get some answers. There is also a flood methodology in this report as we have seen in the past. They are only analyzing HSA accounts that had money either added or withdrawn, leaving aside all the HSA accounts that had no activities.

They have also compared HSA account filers with all other taxpayers. Those who are insured and uninsured, skewing the result on income as well, and so by including the uninsured they get a distorted income amount. So, again, I think they have the wool pulled over the eyes of this Committee. I am ready for a frank and open discussion on this issue, but to skew these reports, to pull the wool over the eyes of this Committee is improper.

So, beyond the fact that enrollment has grown six-fold from the date the GAO looked at, GAO's findings are directly contradicted by information from actual HSA plans, which found that 45 percent of HSA accountholders made less than 45,000 a year. Unlike the 2005 data used by GAO, we have also heard from many employers, whose current experiences demonstrate how HSAs directly benefit more low and middle income workers. And it shouldn't be a surprise, given they have lower premiums.

Mr. Sensor's experience with HSAs also highlights the need for health care consumers to have more information about the price and quality of health care services. As a result of their experience with HSAs, Alegent now posts their quality data and the costs of most services on their website. With a few clicks, you can now find out exactly how much an episode of care any of their nine hospitals will cost you and review their quality data, enabling consumers to make informed decisions about their health care.

Now, I don't believe HSAs are the only solution and that they alone will cure all of our current health care problems, but it is indisputable that because of HSAs, millions of Americans have been able to purchase affordable health insurance coverage for themselves and their families.

Rather than trying to undermine a successful product, we should focus on how we can use HSAs to increase insurance coverage and reduce health care costs. I also hope that we can work together to provide greater price transparency and better quality data to empower all health care consumers in their quest to receive affordable and effective care.

And to that end I ask unanimous consent to submit a letter from the HSA working group, about 35 associations and other groups to this Committee, as well as a survey from the Center for Policy and Research on Health Insurance Plans. It actually has, I think, a better methodology than the official reports we've been getting from the GAO.

Thank you.

[The letter follows:]

HSA Working Group

May 13, 2008

The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways & Means
United States House of Representatives
Washington, DC 20515

The Honorable Dave Camp
Ranking Member, Subcommittee on Health
Committee on Ways & Means
United States House of Representatives
Washington, DC 20515

Dear Chairman Stark and Ranking Member Camp:

As companies and organizations dedicated to helping more individuals and families access affordable and quality health insurance, we are writing to underscore our strong support for Health Savings Accounts (HSAs). We ask that you submit this letter for the official record of your May 14 hearing on HSAs and consumer-driven health plans.

We are pleased and encouraged by the fact that HSAs continue to be a dynamic, consumer-friendly and increasingly popular option for 6.1 million American individuals and families. Recent survey data by America's Health Insurance Plans indicate that HSAs are being utilized as real solutions to make health insurance more affordable for the uninsured. Over the past year, HSA products accounted for 31 percent of new coverage issued in the small-group market and 27 percent of newly purchased policies in the individual market. Further, enrollment in the large group market increased by 36% from January 2007 and now covers 2.8 million lives.

It is against the backdrop of these successes that we convey our concerns about inaccurate conclusions that might be drawn from a recent report by the Government Accountability Office (GAO) titled, "Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes" (GAO-08-474R).

We strongly believe that the GAO report's underlying conclusions that HSAs have served as mere tax shelters for the wealthy are not supported by a complete picture of the HSA experience since their creation.

One of the significant limitations of the GAO report is that the 2005 data analysis is a very thin slice of the lifespan of HSAs, as it was only the second year of the HSA program and only one million lives were covered. Moreover, the data of HSA participants in 2005 needs to be viewed in context, as they reflect a high number of former holders of Medical Savings Accounts (MSAs), who converted their accounts into HSAs upon their creation in early 2004. These individuals and families were largely self-employed individuals and small business owners who typically have higher annual earnings than the general population.

One of the underlying principles of HSAs is to allow consumers and patients to save money tax-free for *future* health care expenses. Allowing and encouraging all Americans to pre-fund their future health care costs through HSAs is sound public policy.

HSAs represent effective financial incentives that are aligned with the best interests of patients, consumers, and employers alike. In fact, HSAs are fulfilling the health care needs of real people who are working hard to find and have access to affordable, quality, and portable personal health coverage.

We look forward to working with you and your colleagues to pursue additional effective solutions to increasing access to affordable health insurance for all Americans and reducing the costs of health care.

Sincerely,

Aetna
America's Health Insurance Plans
American Benefits Council
Aon Consulting, Inc.
Assurant Health
Avaya, Inc.
Business Roundtable
Cigna
Council of Insurance Agents & Brokers
Cummins Inc.
Deere & Company
Express Scripts Inc.
HR Policy Association
International Franchise Association
National Association for the Self-Employed
National Association of Health Underwriters
National Association of Manufacturers
National Business Coalition on Health
National Business Group on Health
National Center for Policy Analysis
National Federation of Independent Business
National Retail Federation
National Roofing Contractors of America
National Taxpayers Union
Retail Industry Leaders Association
Rockwell Collins
The ERISA Industry Committee
The Financial Services Roundtable
The HSA Council, part of the American Bankers Association
UnitedHealth Group
U.S. Chamber of Commerce
WellPoint
Women Impacting Public Policy

Cc: Members of the Subcommittee on Health, Committee on Ways & Means

Chairman STARK. Oh, absolutely, without objection.

I would concur the gentleman's remarks that often our data lags behind the changes and I for instance would be curious. A very small percentage of HSA policyholders actually had savings accounts and I would be curious to know whether that changed. In other words, the growth in policies sold, I think, your data is probably, I'd have no clue.

The question in my mind would be are we just encouraging high deductible plans; and are the people actually putting any money in it, which we don't know. And I think today we can discuss whether that's useful or not, and we've got a panel here. And I would ask all of our witnesses that I will introduce in just a moment if they could address at least estimates or comment on where they think we are since 2005.

Was that data 2005?

Mr. CAMP. Yes.

Chairman STARK. And where we think in the last 3 years times have changed or the approaches have varied, or whether it is fair to extrapolate or not.

We are going to hear from John Dicken, the Director of Health Care with the GAO; from Dr. Michael Chernew, the Professor of Health Care Policy at the Harvard Medical School; from Dr. Linda Blumberg, who is the Principal Research Associate at the Urban Institute; from Ms. Judy Waxman, who is Vice President and Director of Health and Reproductive Rights at the National Women's Law Center; Mr. Wayne Sensor who is CEO of Alegent Health in Omaha, Nebraska. And I ask each of the witnesses to summarize their testimony or expand on it in approximately 5 minutes.

We will have a lot of time during inquiry to dig into your testimony in more detail; and, I would say to the Members who are going to have, I understand, a few procedural votes this morning, I would hope not to recess the Committee for any longer than is necessary. And I would say to the Members if we get one Member from each side of the aisle back after a vote, just commence the hearings, and so we can move right along and not inconvenience the witnesses or the Members.

Mr. Dicken, would you like to proceed?

STATEMENT OF JOHN E. DICKEN, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (GAO)

Mr. DICKEN. Thank you.

Mr. Chairman, Ranking Member Camp, and Members of the Subcommittee, I am pleased to be here today as the Subcommittee discusses issues related to health savings accounts and HSA eligible high deductible health plans.

HSAs were introduced in 2004 and HSA-eligible health plans are now a small but growing share of the private health insurance market with more than 6 million Americans covered. These health plans have three components: first is a deductible, significantly higher than typical with more traditional plans; second is the actual HSA, a tax-advantaged account for paying medical expenses and accumulating savings; and, third, is often a decision-support tool to provide enrollees with standardized information on the cost and quality of health care providers and services.

My remarks today highlight several key points from my written statement, which is based primarily on GAO's April 2008 report entitled, "Health Savings Accounts: Participation Increased and Was More Common Among Individuals with Higher Incomes." As health insurance premiums have continued to rise, more people have purchased HSA-eligible plans, paying lower premiums in exchange for the higher deductible. A series of health insurance carrier surveys reported that the number of lives covered by these plans increased sharply from about 138,000 in September 2004 to an estimated 6.1 million in January 2008.

Participation in HSAs has also grown. Our analysis of IRS data showed that the number of tax filers aged 19 to 64 reporting HSA activity nearly tripled from about 120,000 in 2004 to about 355,000 in 2005. Industry estimates indicate continued growth in HSA participation through 2007. While the enrollment growth has been striking, survey estimates indicate that more than 40 percent of eligible health plan enrollees did not open an HSA. Further, more than 20 percent of these enrollees did not plan to open an HSA citing their inability to afford it or belief that they did not need one.

Turning to those with an HSA, tax filers who reported HSA activity generally had higher incomes than other tax filers. The average, adjusted, gross income for those reporting HSA activity in 2005 was about $139,000 compared with about $57,000 for other tax filers. Such income differences between HSA and other filers existed across all age groups and within different tax filing statuses, such as single or joint ex-filers. The situation was similar for Federal employees enrolled in the Federal Employees Health Benefits Program. In 2005, 43 percent of active employees enrolled in an HSA-eligible plan earned a Federal income of $75,000 or more compared with 23 percent of all enrollees.

Let me turn to how participants funded and used their HSAs. Among all tax filers reporting HSA activity in 2005, average contributions were about $2,100, about double the average withdrawals of about $1,000. Among filers reporting HSA contributions, about 41 percent did not withdraw any funds that year, while about 22 percent withdrew as much or more than they contributed in 2005. This is consistent with statements from industry experts that characterize HSA accountholders as either savers or spenders.

Of the HSA funds withdrawn in 2005, about 93 percent of reported withdrawals were claimed for qualified medical expenses. The remaining 7 percent of withdrawals were reported for nonqualified expenses, which are subject to tax and, if withdrawn before age 65, an additional tax penalty. However, we reported in 2006 that enrollees were sometimes unsure what medical expenses qualified for payment using their HSAs.

Finally, as HSAs attract more participants and average account balances grow, the availability of tools to guide consumers in making informed health care decisions will be even more important. Few HSA-eligible plan enrollees who participated in focus groups we conducted in 2006, researched the cost of services, other than prescription drugs, before obtaining care.

Further, industry experts and employers told us that the tools provided by insurance carriers often did not provide sufficient information to allow enrollees to fully assess the cost and quality

tradeoffs of their purchasing decisions. Overcoming these barriers will likely require time, education and improved tools to provide enrollees with better information about the cost and quality of their health care.

Mr. Chairman, this concludes my statement.

I will be happy to answer any questions that you or Members of the Subcommittee may have.

Thank you.

[The prepared statement of John Dicken follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 10:30 a.m. EDT
Wednesday, May 14, 2008

HEALTH SAVINGS ACCOUNTS

Participation Grew, and Many HSA-Eligible Plan Enrollees Did Not Open HSAs while Individuals Who Did Had Higher Incomes

Statement of John E. Dicken
Director, Health Care

GAO-08-802T

GAO
Accountability-Integrity-Reliability

Highlights

Highlights of GAO-08-802T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

With health care spending increasing, Congress enacted legislation effective in 2004 establishing Health Savings Accounts (HSA) to be coupled with eligible high-deductible health plans. The novel structure of eligible health plans coupled with HSAs has raised questions about who selects them and how they are used. Proponents contend that the lower premiums of the health plans and the tax-free savings potential of HSAs appeal to consumers, while the health plans' high deductibles encourage enrollees to be more astute health care consumers. However, critics are concerned that HSA-eligible plans may attract enrollees who seek lower premiums but lack the resources to contribute to an HSA, and wealthy enrollees who may use the HSA primarily to accumulate tax-advantaged savings.

This statement focuses on (1) participation in HSA-eligible high-deductible health plans and HSAs, (2) the income characteristics of HSA account holders, and (3) the funding and use of HSAs. This statement is based primarily on findings from GAO's April 2008 report entitled *Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes* (GAO-08-474R). For that report GAO reviewed industry data on the participation in HSA-eligible plans and HSAs, and analyzed Internal Revenue Service (IRS) data on tax filers who claimed deductions for HSAs. The statement also draws on findings from related GAO reports issued in 2006.

To view the full product, including the scope and methodology, click on GAO-08-802T. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

May 14, 2008

HEALTH SAVINGS ACCOUNTS

Participation Grew, and Many HSA-Eligible Plan Enrollees Did Not Open HSAs while Individuals Who Did Had Higher Incomes

What GAO Found

GAO found that the number of individuals participating in HSA-eligible high-deductible health plans and HSAs increased significantly since 2004. A series of health insurance carrier surveys reported that the number of lives covered by HSA-eligible plans increased significantly from about 438,000 in September 2004 to an estimated 6.1 million in January 2008. GAO's analysis of IRS data showed that the number of tax filers ages 19 to 64 reporting HSA activity nearly tripled from about 120,000 in 2004 to about 355,000 in 2005. Industry estimates indicated continued growth in HSA participation in 2006 and 2007. However, many HSA-eligible plan enrollees did not open an HSA. From 2005 through 2007, 42 percent to 49 percent of HSA-eligible plan enrollees reported that they had not opened an HSA, and 20 percent to 24 percent did not plan to open an HSA, citing their inability to afford an HSA or a belief they did not need an account.

Tax filers who reported HSA activity and enrollees in certain HSA-eligible plans had higher incomes on average than other tax filers. For example, among tax filers between the ages of 19 and 64, the average adjusted gross income (AGI) for those reporting HSA activity in 2005 was about $139,000, compared with about $57,000 for other filers. About 59 percent of HSA filers had AGIs of $60,000 or more, compared with 26 percent of other tax filers. Moreover, income differences between HSA and other filers existed across all age groups and within different tax filing statuses, such as single or joint tax filers.

Among all filers reporting HSA activity in 2005, average contributions—reflecting both individual and employer contributions—were about $2,100, compared to average withdrawals of about $1,000. Among filers who reported HSA contributions in 2005, about 41 percent did not withdraw any HSA funds that year, while about 22 percent withdrew as much or more than their reported contributions. About 93 percent of reported withdrawals were claimed for qualified medical expenses. Some HSA-eligible plan enrollees GAO interviewed for a 2006 report were unsure what medical expenses qualified for payment using their HSAs, and few researched the cost of services before obtaining care.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you examine issues related to tax advantaged health savings accounts (HSA) and HSA-eligible high-deductible health plans. With health care spending increasing in the United States, Congress enacted legislation effective in 2004 establishing HSAs to be coupled with HSA-eligible high-deductible health plans.[1] The novel structure of HSA-eligible plans coupled with HSAs—a type of consumer directed health plan[2]—has raised questions about who selects them and how they use the accounts. Proponents of consumer-directed health plans contend that the lower premiums of HSA-eligible plans and the tax-free savings potential of HSAs appeal to many consumers, while the high deductibles encourage them to be more astute health care consumers.[3] However, some critics are concerned that HSA-eligible plans may attract enrollees who seek lower premiums but lack the resources to contribute to an HSA, and wealthy enrollees who may seek to use the HSA primarily to accumulate tax-advantaged savings rather than pay for medical expenses.

My comments today are based primarily on findings from our April 2008 report entitled *Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes*.[4] My remarks focus on (1) participation in HSA-eligible high-deductible health plans and HSAs, (2) the income characteristics of HSA account holders, and (3) the funding and use of HSAs.

[1]HSA-related tax advantages were authorized by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 for individuals covered by HSA-eligible health plans—plans that meet minimum deductibles and maximum out-of-pocket spending limits. Pub. L. No. 108-173, §1201, 117 Stat. 2066, 2469. Both employers and individuals may—but are not required to—contribute to HSAs, up to an annual limit.

[2]Consumer-directed health plans generally include three basic components—a health plan with a high deductible; an associated tax-advantaged account to pay for medical expenses under the deductible; and decision-support tools to help enrollees evaluate health care treatment options and costs.

[3]HSA contributions up to annual limits are exempt from income tax, and withdrawals for qualified medical expenses are not federally taxed. Contributions exceeding the limit are subject to federal tax. Withdrawals for nonqualified expenses are also subject to federal tax, and—if withdrawn before age 65—an additional tax penalty.

[4]GAO-08-474R (Washington, D.C.: Apr. 1, 2008).

In conducting our work for the April 2008 report, we analyzed industry data, Internal Revenue Service (IRS) data, and nationally representative survey data. To examine participation in HSA-eligible health plans we obtained estimates of the number of lives covered by HSA-eligible health plans from 2004 to 2007 from America's Health Insurance Plans (AHIP).[5] For this statement we updated this information to 2008 based on AHIP's more recent estimates. To examine participation in HSAs, we analyzed 2004 and 2005 tax filer data from the IRS Statistics of Income (SOI) sample to estimate the number of tax filers reporting HSA activity in those years,[6] reviewed various estimates of the number of HSAs in 2006 and 2007 that were reported in health care and financial industry publications,[7] and examined data from nationally representative surveys of HSA-eligible plan enrollees conducted from 2005 to 2007.[8] To examine income characteristics of HSA account holders, we analyzed IRS tax data from the 2005 SOI sample. To examine funding and use of HSAs, we analyzed IRS tax data from the 2005 SOI sample and data from nationally representative employer surveys conducted from 2005 through 2007.[9] We performed this work from September 2007 through February 2008, and a detailed explanation of our scope and methodology is included in the report. I will also draw on findings from our related reports issued in 2006.[10] We conducted all our work in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[5]AHIP is a trade association representing health insurers.

[6]We defined HSA activity for a given year as any reported contributions to or withdrawals from an HSA in that year.

[7]We also interviewed officials from the organizations that prepared the estimates—Atlantic Information Services, Financial Research Corporation, and Information Strategies Incorporated—however, we did not verify the reliability of the estimates.

[8]Blue Cross Blue Shield Association, CDHP Member Experience Surveys, 2005, 2006, and 2007.

[9]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: Annual Survey* (Menlo Park, Calif., and Chicago, Ill.: 2005, 2006, and 2007) and Mercer, *National Survey of Employer-Sponsored Health Plans* (New York, N.Y: 2005, 2006, and 2007).

[10]A list of these related GAO products is included at the end of this statement.

In summary, we found that the number of individuals participating in HSA-eligible health plans and HSAs increased significantly since 2004; however, HSA-eligible health plans still represented a small share (about 2 percent in 2006) of individuals with private health coverage. While participation in both the eligible health plans and the HSAs grew, survey estimates indicate that more than 40 percent of the health plan enrollees did not open an HSA, citing among other reasons their inability to afford an HSA or a belief that the accounts were not needed. Tax filers who reported HSA activity in 2005 had higher incomes on average than other tax filers—about $139,000 compared with about $57,000. Among all filers reporting HSA activity in 2005, average contributions—reflecting both individual and employer contributions—were about $2,100, compared to average withdrawals of about $1,000. Among filers who reported HSA contributions in 2005, about 41 percent did not withdraw any HSA funds that year, while about 22 percent withdrew as much or more than their reported contributions. About 93 percent of reported withdrawals were claimed for qualified medical expenses. We reported in 2006 that some HSA-eligible plan enrollees we interviewed were unsure what medical expenses qualified for payment using their HSAs, and that few researched the cost of services before obtaining care.

Background

Most Americans—about 202 million in 2006—receive health coverage through private health plans. Over the past several years, insurers have expanded their portfolio to include insurance plans with high deductibles, lower premiums, and, generally, an associated savings account to pay for services up to the deductible. These consumer-directed health plans are designed to reduce health care spending and encourage more consumer control. To help achieve these goals, insurers typically offer online tools to enrollees designed to help them evaluate the cost and quality of health care services. Experts suggest that reliable information about the cost of particular health care services and the quality of specific health care providers would help enrollees become more actively engaged in making health care purchasing decisions.

Beginning in 2004, insurers began to market HSA-eligible consumer-directed health plans. HSA-eligible health plans are required to meet certain statutory criteria, including minimum deductible amounts, which are higher than health plan deductibles on average, and maximum limits

on enrollee out-of-pocket spending.[11,12] HSA-eligible plans are sold either to an individual or through group plans, such as those offered by employers.

HSAs are tax-advantaged savings accounts established to pay for qualified medical expenses.[13] Individuals are eligible to open an HSA and contribute funds if they are enrolled in an HSA-eligible plan and have no other health coverage, with limited exceptions.[14] Both employers and individuals may—but are not required to—contribute to HSAs, up to an annual limit.[15] Individuals may claim a deduction on their federal income taxes for their HSA contributions not exceeding the limit. HSA withdrawals for qualified medical expenses are not federally taxed; withdrawals for nonqualified expenses are subject to tax and, when withdrawn before age 65, an additional tax penalty. HSA account holders may access their account funds by check, by debit card, or by allowing providers to directly debit their account funds. Account administrators, such as financial institutions, report to IRS the contributions and withdrawals made to and from the accounts they manage, and individual account holders report to IRS the amount of withdrawals they used for qualified medical expenses or other expenses. Unused HSA balances may accumulate from year to year without limit and earn interest. HSAs are owned by the account holder and individuals may keep their accounts if they switch jobs or are no longer enrolled in an HSA-eligible health plan.

[11] An out-of-pocket spending limit is the most an enrollee is required to pay toward the cost of covered services. The out-of-pocket spending limit includes deductibles and other payments, but not premiums.

[12] These amounts are annually adjusted for cost-of-living increases. In 2008, the minimum deductible amount is $1,100 for single coverage and $2,200 for family coverage, and the maximum limit on enrollee out-of-pocket spending is $5,600 for single coverage and $11,200 for family coverage.

[13] Qualified medical expenses are generally identified under the Internal Revenue Code (26 U.S.C. § 213(d)).

[14] Limited coverage (including specific injury or accident, disability, dental care, or vision care) in addition to the HSA-eligible plan is permissible.

[15] The annual contribution limit is adjusted annually for inflation. In 2008, contributions are allowed up to $2,900 for single coverage or $5,800 dollars for family coverage, regardless of the amount of the deductible. In 2007, contributions were allowed up to $2,850 for single coverage or $5,650 for family coverage. Prior to 2007, contributions were limited to the lesser of the deductible amount for the HSA-eligible plan or the limits specified for each year.

Participation in HSA-Eligible Plans and HSAs Increased Significantly, and Many HSA-Eligible Enrollees Did Not Open an HSA

Industry estimates indicate significant increases in the number of individuals covered by HSA-eligible health plans. For example, a series of insurance carrier surveys conducted by AHIP found that the number of lives covered by HSA-eligible plans increased significantly from about 438,000 in September 2004 to an estimated 6.1 million in January 2008.[16] Despite the growth, HSA-eligible plan coverage represented only about 2 percent of individuals with private health coverage in 2006.[17]

Participation in HSAs also increased significantly. IRS data show that the number of tax filers between the ages of 19 and 64 reporting HSA activity nearly tripled from about 120,000 in 2004 to about 355,000 in 2005. In addition, although industry estimates varied, all indicated continued growth in HSA participation in 2006 and 2007. For example, one industry publication estimated that the number of HSAs managed by major financial institutions more than doubled between 2006 and 2007.[18]

Despite the growth in HSA participation, many HSA-eligible plan enrollees did not open an HSA. Nationally representative surveys of HSA-eligible plan enrollees conducted in 2005 through 2007 found that 42 percent to 49 percent reported that they had not opened an HSA, and 20 percent to 24 percent did not plan to open one.[19] Reasons survey respondents cited for not planning to open an HSA included that they could not afford them or they did not believe they needed them. On the basis of an analysis of publicly available survey data and data obtained from IRS, we also reported that roughly 45 percent of HSA-eligible plan enrollees in 2004 did not report contributions to an HSA.[20] Similarly, industry representatives we spoke with told us that many HSA-eligible plan enrollees did not have an HSA. The representatives also said that they expect that there would

[16]America's Health Insurance Plans, *January 2008 Census Shows 6.1 Million People Covered by HSA/High-Deductible Health Plans* (Washington, D.C.: April 2008). The estimates included plans from the individual and group markets.

[17]GAO analysis of America's Health Insurance Plans' 2006 and 2007 estimates of lives covered by HSA-eligible health plans, and the U.S. Census Bureau's 2006 Current Population Survey estimate of lives covered by private health insurance.

[18]Atlantic Information Services, Inc., "Number of HSAs Doubles Over Past Year; Firms Now Hold Nearly $2 Billion, ICDC Finds," *Inside Consumer-Directed Health Care* (Mar. 9, 2007).

[19]Blue Cross Blue Shield Association, CDHP Member Experience Surveys, 2005 through 2007.

[20]See GAO-06-709.

always be some share of eligible consumers who would choose not to open an HSA.

HSA Account Holders Reported Higher Incomes than Other Tax Filers

Tax filers who reported HSA activity and enrollees in certain HSA-eligible plans had higher incomes on average than other tax filers. Among tax filers between the ages of 19 and 64, the average adjusted gross income (AGI) for those reporting HSA activity in 2005 was about $139,000, compared with about $57,000 for other filers.[21] About 59 percent of HSA filers had AGIs of $60,000 or more, compared with 26 percent of other tax filers.[22] Moreover, income differences between HSA and other filers existed across all age groups. (See fig. 1.) Income differences between HSA and other filers also existed within different tax filing statuses, such as single or joint tax filers. In 2006 we reported similar findings based on different data sources covering different time periods. For example, we reported that about 51 percent of HSA filers in 2004 had AGIs of $75,000 or more, compared with 18 percent of all tax filers under age 65.[23] In addition, we reported that among active federal employees enrolled in the Federal Employees Health Benefits Program in 2005, 43 percent of HSA-eligible plan enrollees earned federal incomes of $75,000 or more, compared with 23 percent for all enrollees.[24]

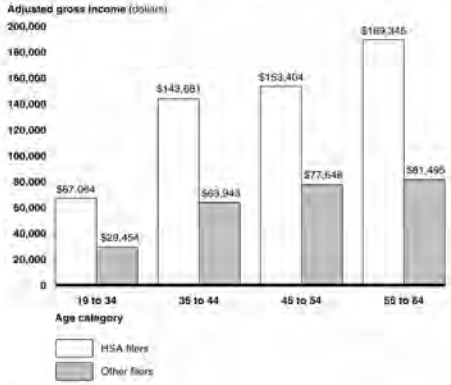
[21]The median income of HSA filers in 2005 was about $72,000 compared with about $32,000 for other filers.

[22]Other tax filers include both insured and uninsured individuals. The uninsured tend to have lower incomes than those with health insurance coverage. For returns of married couples filing jointly, the AGI included the combined AGIs of both filers.

[23]See GAO-06-798.

[24]See GAO-06-271.

Figure 1: Comparison of HSA and Other Tax Filers' Average Adjusted Gross Income by Age, 2005



Source: GAO analysis of IRS data.

Notes: Analysis was limited to tax filers between the ages of 19 and 64. HSA filers included those reporting any contributions to or withdrawals from an HSA. Contributions include those made by individual tax filers or by employers or other individuals on their behalf, but do not include any funds that were transferred to an HSA from a medical savings account. Withdrawals did not include those made to avoid a tax penalty by removing contributions that were in excess of the allowable limits, or those made to transfer funds from one HSA to another. For returns of married couples filing jointly, returns were categorized based on the age of the primary tax filer, and the AGI included the combined AGIs of both filers.

HSA Contributions Exceeded Withdrawals and Most Withdrawals Were Claimed for Qualified Medical Expenses

The total value of account holder and employer HSA contributions in 2005 was about twice that of account holder withdrawals—about $754 million compared to $366 million. Among all filers reporting HSA activity, the average HSA contribution was about $2,100, the average HSA withdrawal was about $1,000, and average contributions and withdrawals generally increased with both income and age. Employer survey data provided varying estimates of the extent to which employers contributed to their employees' HSAs. For example, a series of surveys reported that more than a third of large employers offering HSA-eligible plans did not contribute to their employees' HSAs in 2005, 2006, or 2007.[25] Another survey reported that 47 percent of small and large employers offering HSA-eligible plan coverage for families did not contribute to their employees' HSAs in 2007.[26]

The extent to which account holders withdrew HSA funds varied, but of the funds withdrawn, most were claimed for qualified medical expenses. Among filers who reported HSA contributions in 2005, about 41 percent did not withdraw any HSA funds that year, while about 22 percent withdrew as much or more than their reported contributions.[27] This is consistent with statements from industry experts that characterized HSA account holders as either savers or spenders, where savers primarily used HSAs as a tax-advantaged savings vehicle.[28] Of the HSA funds that were withdrawn in 2005, about 93 percent were claimed for qualified medical expenses. The remaining 7 percent of withdrawals were for nonqualified expenses, which are subject to tax and, if withdrawn before age 65, an additional tax penalty.

We reported in August 2006 that some HSA-eligible plan enrollees we interviewed were unsure what medical expenses qualified for payment using their HSAs, and few researched the cost of services before obtaining

[25]Mercer, *National Survey of Employer-Sponsored Health Plans*, 2005, 2006, and 2007.

[26]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*.

[27]HSA withdrawals may exceed contributions in a given year if balances are carried over from prior years.

[28]GAO-06-514.

care, although many researched the cost of prescription drugs.[29] In addition, we reported in April 2006 that consumer-directed health plan experts and employers told us the tools provided by insurance carriers to assist consumers in assessing the price and quality of health care providers and services did not provide sufficient information to allow enrollees to fully assess the cost and quality trade-offs of health care purchasing decisions.[30] They cited several reasons for this, including potential legal barriers to greater price transparency and a lack of consensus on what would make ideal quality measures.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members of the Subcommittee may have.

For future contacts regarding this statement, please contact John E. Dicken at (202) 512-7114 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Randy DiRosa, Assistant Director; Gerardine Brennan; Stephen Ulrich; and Timothy Walker made key contributions to this statement.

[29]See GAO-06-798. Information on HSA-eligible plan enrollee experiences was gathered from focus groups we conducted of employees from three large employers that offered HSA-eligible health plans. These focus groups also revealed that participants generally reported positive experiences, but most would not recommend the plans to consumers who use maintenance medications, have a chronic condition, have children, or may not have the funds to meet the high deductible.

[30]See GAO-06-514.

Related GAO Products

Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes. GAO-08-474R. Washington, D.C.: April 1, 2008.

Health Savings Accounts: Early Enrollee Experiences with Accounts and Eligible Health Plans. GAO-06-1133T. Washington, D.C.: September 26, 2006.

Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans. GAO-06-798. Washington, D.C.: August 9, 2006.

Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage. GAO-06-514. Washington, D.C.: April 28, 2006.

Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts. GAO-06-271. Washington, D.C.: January 31, 2006.

Chairman STARK. Thank you.

Dr. Chernew, would you like to enlighten us?

STATEMENT OF MICHAEL E. CHERNEW, PH.D., PROFESSOR OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL, BOSTON, MASSACHUSETTS

Mr. CHERNEW. Thank you, Chairman Stark and Ranking Member Camp and Members of the Health Subcommittee for inviting me here today to speak to you about this important topic.

I believe that we all share the goal of trying to reform the health care system in ways that will improve the quality of care and control the costs. Today, I am going to speak with you about how cost-sharing can help us meet those objectives. I should preface my remarks by saying that as an economist I believe in markets.

I believe consumers in general are best situated to assess their desires and act accordingly in the market. But, as a growing body of research demonstrates, markets do not always work well. And I think health care is an area where we were concerned about markets failing.

There are several reasons why I think health care markets are particularly problematic. First, the consequences of a poor decision in health care are worse than the consequences of poor decisions in many other markets, including, for example, death. So it matters if people don't make the right choices.

Second, in health care markets information is particularly complex. It is very difficult to ask consumers to make judgments about medical things. It is particularly difficult, because many times those decisions are being made in situations in which the individual is stressed. They might be very emotional.

In some cases, they are cognitively impaired. It is hard to expect people in those situations to respond appropriately to price signals. Moreover, in many cases, the decisions need to be made quickly, making it difficult to shop or make the decision that we might think is appropriate in retrospect.

Finally, there are a series of institutional details about health care markets, including the role of physicians, and including the restrictions placed on patients sometimes by insurers that may mute their response to price signals. I'd like to talk for a moment about the evidence examining cost-sharing in health care markets.

The first thing, and I say this is soothing to me as an economist, if you charge people more, they consume less. That's true of almost all markets. What is more disturbing in health care is I think there is a large and growing body of research that suggests that when you charge people more for their health care, they cut back on appropriate treatment to the same extent as they cut back on inappropriate treatment.

There is evidence on that point dating back decades from a randomized trial, perhaps the strongest design suggesting that that is true. There is a growing body of evidence now, looking at how people managed their chronic disease, particularly pharmaceuticals, that suggests that when you charge people more for their services they consume them less often.

Some particular results: In one study, 21 percent of patients when charged a modest co-pay dropped their use of cholesterol

medications, compared to 11 percent in a control group. One study suggested a doubling of co-pays, reduced use of hypertensive medications by 10 percent amongst individuals with hypertension; and there's a long list of studies of this nature.

Moreover, we are very interested in quality. A lot of resources have been devoted to measuring quality. Some studies that we have done, as well as others suggest that when patients are charged they perform worse on the indicators of quality that we have developed—things like mammograms.

And finally, and perhaps not surprisingly, in the study we have recently published we have found that low income individuals are more sensitive to price than higher income individuals. In our study, people with diabetes were three times more sensitive to price when taking their blood pressure medications if they lived in a low income area compared to other individuals.

The solution, incidentally, I don't believe, is to abandon caution cost sharing completely. What I think is true is that we need to simply have smarter cost sharing. My colleagues and I have been advocating an idea called "value-based insurance design," which advocates keeping co-pays low on high value services.

There is a number of employers, (Pitney Bowes, the University of Michigan), insurers (Aetna and their Active Health Management subsidiary), employee benefit consulting firms, (Hewitt and Associates), that have been at the vanguard of designing these more sophisticated cost-sharing plans. In order to make these things work, I need to emphasize we need more and better clinical research such as embodied by comparative effectiveness research. We need more and better health services research to understand the ways individuals responsd to information and price signals. We need to know more so we can be more sophisticated in designing programs that will help us meet our objectives.

So in summary let me say just because there are areas where cost-sharing works, and I believe there are, that doesn't imply that it works for everybody more broadly. Similarly, just because there is an area where cost-sharing does not work doesn't imply that cost-sharing can never work. In the future I think we need to be more sophisticated and strive to avoid financial barriers to high quality care and successful treatment for patients with chronic disease.

So thank you very much for your time and I welcome your questions.

[The prepared statement of Michael Chernew follows:]

Prepared Statement of Michael E. Chernew, Ph.D., Professor of Health Care Policy, Harvard Medical School, Boston, Massachusetts

Thank you, Chairman Stark, Ranking Member Camp, and Members of the Subcommittee for inviting me to testify on the impact of cost sharing on outcomes in health care markets. Rising health care costs represent perhaps the most important long-run challenge facing the American health care system and even the economy overall. At the same time, we worry that too often the quality of care delivered by the health care system is below the level we would desire. I believe many of you share my goal of finding ways to reform the health care system to control costs and improve quality.

Today I am going to talk about the role that patient cost sharing at the point of service may play in achieving those goals. Requiring patients to pay more when they receive care is among the solutions purchasers have adopted to address the fiscal pressure represented by rising costs. Relatively new health insurance packages,

such as high deductible plans that may be accompanied by Health Savings Accounts, exemplify this trend. Yet the movement towards greater cost sharing by patients at the point of services extends much more broadly. Patient copayment rates and deductibles have been rising even in more conventional plans.

I will make two basic points. First, patient cost sharing is neither good nor bad. Its merits depend on the context. In some cases cost sharing can promote efficiency and quality. In other cases it can lead to inefficiency and poor health outcomes. Second, a greater investment in clinical and behavioral research is needed to help us design systems that can use cost sharing and other tools to achieve our health care goals.

I would like to preface my remarks by noting that, as an economist, I believe that market mechanisms are, in general, the best way to achieve efficient allocations of resources. In most settings consumers should determine what goods and services they desire and act accordingly in the market place. Over the course of our history reliance on free markets and consumer sovereignty has served us very well. However, my general appreciation of markets does not imply a belief that they always work well. There is a growing body of evidence in economics documenting deviations between consumer behavior and standard economic theory. For example, contrary to standard economic models, evidence suggests that consumers are much more likely to participate in retirement savings programs if they are automatically enrolled, with the option of opting out, than if they must actively choose to participate.[1] Similarly, in contrast with standard economic models, evidence suggests that when consumers are given a wide choice of products (e.g. different varieties of jelly) they are less likely to purchase any product than when they are given only a few choices.[2] These paradoxes do not negate the merits of markets, but they do enrich our understanding of individual behavior and can suggest that policy interventions may improve welfare.

Having studied health care markets for about two decades I believe that, despite my general faith in markets, health care markets are an instance in which we should be cautious about blindly relying on market principles. There are a number of reasons health care markets are unique. Perhaps most importantly, the outcomes associated with poor consumer decisionmaking can be more serious, including death, than in other markets. Furthermore, institutional details of decisionmaking, including the complexity of information, increase the potential for undesired outcomes. It seems unreasonable to expect a patient to choose between bare metal and drug eluding stents when the medical evidence is conflicting. Even the choice of hospital or physician may be difficult because of the many attributes of different providers and because of complex provider-plan relationships. For example, physician privileges may be limited to certain hospitals, plan provider networks often limit access to certain doctors and hospitals, and physician practices may be closed to new patients. These institutional details will limit the ability of consumers to respond to price signals. These decisions are even more difficult when patients are cognitively impaired, very emotional or stressed, or when they need to make decisions quickly. One would not expect, for example, a patient suffering chest pain will be able to weigh tradeoffs between institutions prior to seeking care. The role of physicians complicates the ability of patients to weigh options. Certainly patients have a say in their care, but in many situations they are heavily influenced by physicians and it may be unlikely (perhaps appropriately in some cases) that they would respond to market signals if those signals conflicted with their physicians advice. Finally, consumers desire protection against the financial risk of illness. In situations in which cost sharing does not alter patient behavior, greater cost sharing does nothing to change overall spending and has no beneficial incentive effects. It simply represents a tax on sick patients. In these instances, greater cost sharing has no beneficial incentive effects and just represents a tax on patients. For these reasons, policymakers and private purchasers must consider the potential for unintended outcomes when promoting interventions such as greater consumer cost sharing.

Cost sharing reduces utilization and expenditures

As with any good, the demand for health care services is responsive to price. When patients are charged more for care, they will consume fewer health care services. Estimates from a randomized trial suggest that when patients were required to pay 95% of their care (up to an out-of-pocket maximum that was based on their income) they reduced spending by over 30%.[3] The responsiveness may be even higher as cost sharing requirements grow as a share of income. To proponents of high cost sharing, this response is desirable. They could rightly note that considerable evidence suggests that greater use of health care services is not consistently related to better outcomes and that it is likely we could reduce utilization and spending without adversely affecting the health of Americans. In this view of the world, con-

sumers, when faced with the correct incentives, would drive the system to efficiency as we believe they do in most other markets.

When facing higher cost sharing in health care consumers forgo important services

As much as it pains me to admit it, important aspects of standard economic models appear to be often violated in health care markets. Specifically, economists often assume that if prices charged to consumers rise, individuals will forgo less valuable services and continue to consume services of high value. Extensive evidence suggests that in health care markets this assumption may be incorrect in many instances. For example, the RAND health insurance experiment, which documented patient response to cost sharing, found that patients reduced utilization of services deemed clinically appropriate by the same amount as they reduced the use of services deemed clinically inappropriate.[4]

Similarly, more recent research has documented that relatively modest increases in cost sharing reduces utilization of important medications for managing chronic disease.[5 11] For example, Goldman and colleagues report that a doubling of copayments reduced use of anti-diabetes medications by patients with diabetes by 23% and reduced use of anti-hypertension medications by patients with hypertension by 10%.[7] Huskamp and colleagues report that when an employer increased cost sharing requirements by about $10 to $20 per prescription (depending on the exact medication), that 21% of patients stopped taking their medication for high cholesterol (compared to 11% in a control group).[8] Reducing copayment rates seems to have the opposite effect. Research that my colleagues and I published in January found that reduction in copayments of about $10 per prescription increased patient adherence to treatment regimes for chronic disease.[12] Recent reviews of the literature confirm these conclusions.[6,13]

Interestingly, while a lot of attention has been devoted to measuring the quality of care in this country, we seldom appreciate the impact that greater cost sharing may have on quality of care measures. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) is a list of quality indicators maintained by the National Committee of Quality Assurance (NCQA). Forthcoming work that my colleagues and I have done, examining a subset of those measures, suggests that higher cost sharing will reduce quality.[14] Other research that Trivedi and colleagues published supports that finding.[15] If we care about quality, and I truly hope we do, we must be concerned about the impact of cost sharing.

Not surprisingly, cost sharing may affect disparities in health care related to income. We have recently published a study suggesting that the impact of higher cost sharing is greater among lower income individuals.[16] Specifically, we found that individuals living in low income areas were much more sensitive to price than individuals in high income areas. For example, patients with diabetes in low income areas were over three times more sensitive to costs when using blood pressure medication, a very important component of diabetes care, than patients in high income areas. This is consistent with results from the Rand Health Insurance experiment that found the adverse health effects related to cost sharing were limited to patients with specific chronic diseases (hypertension and vision) and greater among low income individuals.[17]

It is important to assess how these results relate to health outcomes. In theory we should expect to see adverse consequences of reduced use of high value services. Evidence on this point is still developing, and conflicting evidence can be found, but I believe the best evidence suggests adverse consequences of higher cost sharing. Hsu et al. report that higher cost sharing for prescription drugs had worse physiological outcomes (e.g. blood pressure), more visits to the emergency room, and even greater mortality.[18] The savings associated with reduced drug spending were almost completely offset by the higher non-drug spending. Chandra et al. report offsets of lesser magnitudes, but the basic message, that high cost sharing can lead to worse compliance with important health care services and, in turn, result in worse health outcomes, is supported.[19]

Proponents of cost sharing might argue that this evidence underscores the importance of patient education. Certainly patient education is important (though I might add not costless). While I believe education interventions can improve compliance with important services, I am skeptical that it can substantially reduce the price sensitivity of patients to higher cost sharing. Our study of copay reductions that I referred to earlier, which demonstrated how patients responded to lower copayment rates, was conducted in a setting that already had a sophisticated care management intervention in which patients and physicians were contacted about their care and the results suggested the responsiveness to cost sharing was similar to that in other studies.[12]

It is important to recognize that the fact that consumers market poor decisions in health care markets does not mean that there are not settings where markets in health care work well, particularly in situations that are relatively straightforward and consumers have time to decide. Moreover, some consumers are undoubtedly more capable of successfully navigating markets than others. Certainly when the stakes are high, some consumers can do a better job of making decisions than others. Identification of patients or situations in which markets work well does not imply that market mechanisms should be used without modification in health care any more than identification of patients or situations in which markets cannot work implies markets should never be used.

Towards smarter cost sharing

The fundamental question is how we can design our system to recognize the failures of markets and heterogeneity of patients and treatments. Purchasers and policymakers must strive to design benefit packages that recognize the variation in value that health care services offer and attempt to avoid creating financial barriers for access to high value services. The paradigm of Value Based Insurance Design (VBID) reflects this approach, arguing that copays should be kept low for high value services.[20]

Several employers, insurers and benefit consulting firms have begun to adopt VBID style benefit packages. For example, Pitney Bowes reduced cost sharing requirements for important chronic disease medications and reported very favorable results. The University of Michigan designed a benefit package for employees and dependents with diabetes that focused on minimizing financial barriers to access for important services. Insurers such as Aetna have developed a range of initiatives related to VBID, with ActiveHealth Management (a subsidiary of Aetna) using its sophisticated care manage information system as a platform to support VBID. Hewitt Associates, a large employee benefit consulting firm has begun consulting with clients for such programs. These are only a few examples, but they demonstrate the feasibility of such a clinically sensitive approach to cost sharing.

VBID programs are just in their infancy and are no panacea for all of the challenges facing the health care system. Yet to the extent that consumerism, and more specifically cost sharing, is a part of the solution, VBID can help mitigate adverse effects. Moreover, VBID programs can support quality improvement initiatives by removing barriers to the services being promoted.

The potential of sophisticated cost sharing programs such as VBID depends on our ability to support the health services research upon which these programs rely. Not only do we need the type of research that is encompassed by comparative effectiveness research, but we also need greater investment in the social science research that helps us understand patient behavior. Funding of such work will enable us to provide answers to the central questions concerning how we can design a better health care system capable of controlling costs, maintaining (or even improving) the quality of care, and providing patients with the autonomy to make decisions central to their well-being.

Summary

Greater patient responsibility for the costs of their care will undoubtedly be an important part of the healthcare system in the future. However, details of the health care market suggest that cost sharing may have both beneficial and detrimental effects. Proponents of cost sharing focus on situations in which there is overconsumption of care or consumers can be expected (but fail in practice) to shop for the provider offering the best price/quality combination. In these cases, cost sharing can encourage efficient consumption of care. However, in other cases, when care is appropriate or when consumers cannot respond to market signals, cost sharing can lead to worse outcomes. Evidence suggests that in many situations cost sharing will reduce the likelihood that patients will consume appropriate services. This could lead to hospitalization, emergency room visits, and even death. Even if the cost sharing does not alter patient behavior, the associated cost shifting reduces well-being. Specifically, consumers' desire to mitigate some of the financial risk associated with illness suggests that it is difficult to rely on the price mechanism to allocate resources in the same manner as in other markets. If we charge patients the full cost when they need health care services, we would be transferring a substantial risk to patients that is generally not considered by economists to be optimal. More sophisticated cost sharing programs, supported by rigorous clinical and health services research are needed to balance our need to control spending with our desire to get the most from our health care system.

Thank you very much for the opportunity to speak with you today and I welcome your questions.

References

1. Choi JJ, Laibson D, Madrian B, and Metrick A, *Optimal Defaults and Active Decisions.* 2005. **NBER Working Paper #11074**.

2. Iyengar SS and Lepper MR, *When Choice Is Demotivating: Can One Desire Too Much of a Good Thing?* Journal of Personality and Social Psychology, 2000. **79**(6): p. 995–1006.

3. Manning WG, Newhouse JP, Duan N, Keeler EB, and Liebowitz A, *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment.* The American Economic Review, 1987. **77**(3): p. 251–257.

4. Siu AL, Sonnenberg FA, Manning WG, Goldberg GA, Bloomfield ES, Newhouse JP, et al., *Inappropriate use of hospitals in a randomized trial of health insurance plans.* New England Journal of Medicine, 1986. **315**(20): p. 1259–66.

5. Gibson TB, McLaughlin CG, and Smith DG, *A Copayment Increase for Prescription Drugs: the Long-term and Short-term Effects on Use and Expenditures.* Inquiry, 2005. **42**(3): p. 293–310.

6. Gibson TB, Ozminkowski RJ, and Goetzel RZ, *The Effects of Prescription Drug Cost Sharing: A Review of the Evidence.* American Journal of Managed Care, 2005. **11**(11): p. 730–740.

7. Goldman DP, Joyce GF, Escarce JJ, Pace JE, Soloman MD, and Laouri M, *Pharmacy Benefits and the Use of Drugs by the Chronically Ill.* The Journal of the American Medical Association, 2004. **291**(19): p. 2344–50.

8. Huskamp HP, Deverka PA, Epstein AM, Esptein RS, McGuigan KA, and Frank RG, *The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending.* New England Journal of Medicine, 2003. **349**(23): p. 2224–232.

9. Landsman PB, Yu W, Liu X, Teutsch SM, and Berger ML, *Impact of 3-tier Pharmacy Benefit Design and Increased Consumer Cost-Sharing on Drug Utilization.* The American Journal of Managed Care, 2005. **11**(10): p. 621–8.

10. Soumerai SB, McLaughlin TJ, Ross-Degnan D, Casteris CS, and Bollini P, *Effects of a limit on Medicaid drug-reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia.* New England Journal of Medicine, 1994. **331**(10): p. 650–5.

11. Tamblyn R, Laprise R, Hanley JA, Abrahamowicz M, Scott S, Mayo N, et al., *Adverse events associated with prescription drug cost-sharing among poor and elderly persons.* The Journal of the American Medical Association, 2001. **285**(4): p. 421–9.

12. Chernew ME, Shah MR, Wegh A, Rosenberg SN, Juster IA, Rosen AB, et al., *Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment.* Health Affairs, 2008. **27**(1): p. 103–112.

13. Goldman DP, Joyce GF, and Zheng Y, *Prescription Drug Cost Sharing. Associations with Medical Utilization and Spending and Health.* The Journal of the American Medical Association, 2007. **298**(1): p. 61–27.

14. Chernew ME and Gibson TB, *Cost Sharing and HEDIS Performance.* Medical Care Research and Review, Fourthcoming 2008.

15. Trivedi AN, Rakowski W, and Ayanian JZ, *Effect of cost-sharing on screening mammography in Medicare Health Plans.* New England Journal of Medicine, 2008. **358**(4): p. 375–383.

16. Chernew ME, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, and Fendrick AM, *Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care.* Journal of General Internal Medicine, 2008.

17. Newhouse JP, *Free for All. Lessons from the RAND Health Insurance Experiment.* 1996, Cambridge, MA.: Harvard University Press.

18. Hsu J, Price M, Huang J, Brand R, Fung V, Hui R, et al., *Unintended consequences of caps on Medicare drug benefits.* New England Journal of Medicine, 2006. **354**(22): p. 2349–59.

19. Chandra A, Gruber J, and McKnight R, *Patient Cost-Sharing, Hospitalization Offsets, and the Design of Optimal Health Insurance for the Elderly.* 2007. **NBER Working Paper No. W12972**.

20. Chernew ME, Rosen AB, and Fendrick AM, *Value-Based Insurance Design.* Health Affairs, 2007. **26**(2): p. w195–w203.

Chairman STARK. Thank you.

Dr. Blumberg, would you like to proceed please?

STATEMENT OF LINDA J. BLUMBERG, PH.D., PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Ms. BLUMBERG. Mr. Chairman, Mr. Camp and distinguished Members of the Subcommittee, thank you for inviting me to share my views on health savings accounts and their implications for cost-containment and the distribution of health care financing burdens.

The views I express are mine alone and should not be attributed to the Urban Institute, its trustees or its funders. In brief, my main points are the following.

The related issues of a large and growing number of uninsured Americans and the escalating cost of medical care create problems of limited access to necessary medical care for millions of Americans; financial hardship for many households, and severe budgetary pressures on the public health care safety net as well as on Federal and State government. However, HSAs are not the solutions to these pressing national concerns.

HSAs provide additional subsidies to the people most likely to purchase health insurance—even in the absence of no subsidy at all—those with high incomes. As income and marginal tax rates increase, the value of the tax exemption increases as well, and the interest, dividends and capital gains earned on HSA balances grows in addition. Because most of the uninsured have low incomes and get little to no value from tax exemptions, the subsidies are very poorly targeted for expanding coverage.

Because of the highly skewed nature of health care spending, the highest spending 10 percent of the population accounts for 70 percent of total health expenditures, cost containment strategies that do not deal substantially with the high users of health care services will not have a significant effect on overall spending.

The cost saving potential of HSAs is on the spending before the deductible is reached, and most of health care spending occurs by high users of services after the deductibles are met. This significantly limits the ability of HSAs to lower systemwide health care spending. But, to the extent that the high deductible plans raise costs for high cost users, their use of medical services may fall, but there are no provisions to help these patients choose the services most important to their health. So reductions in care could lead to expensive, catastrophic health consequences in the long run. Because high deductible plans with or without HSAs place greater financial burdens on frequent users of medical care than do comprehensive policies, they tend to attract healthier enrollees. This selection can raise costs for the less healthy. Unless the costs of the high users of care are spread more broadly by manipulating premiums across plan types or through regulation or subsidization, this dynamic will make coverage less affordable for those with the greatest medical needs.

Despite lower premiums compared with comprehensive plans, high deductible HSA plans have so far failed to attract many low-income, uninsured individuals and families. In addition to the fact that they get little tax benefit, they often do not have assets to cover the high deductibles. The one size fits all high deductible policy under the HSA legislation is flawed, since for example the $2200 deductible could be financially ruinous for a low income fam-

ily, while the same deductible could have virtually no cost containment impact for a high income family.

Roughly half of those with HSA-compatible, high deductible policies do not open HSAs despite the tax advantages. Two-thirds of employers offering single coverage through high-deductible/HSA combinations report making no contribution to the HSAs of their workers. As a consequence, low income or high health care-need workers with no choice of coverage, but a high deductible/HSA plan are likely to be exposed to much larger out-of-pocket financial burdens than they would be under a comprehensive policy.

At present, the legal use of HSAs is far more tax-favored than is any other health or retirement account. Contributions, earnings, and withdrawals for HSAs can be tax free, if spending is health-related. However, there is no mechanism in place other than being subjected to a general tax audit to verify that spending out of HSA balances is actually being done for medical purposes.

Conversely, Medical Flexible Spending Accounts do have verification mechanisms in place that add very little to the costs of the plans. Having verification requirements would prevent the legal use of HSAs as a general tool of tax evasion.

Effective expansions of health insurance coverage will require subsidies targeted to those with modest incomes, and possibly those with high medical care needs as well, a guaranteed source for obtaining adequate, affordable coverage, and ideally a requirement or guarantee that all individuals have insurance coverage. Effective cost containment will require research and investment in a number of promising strategies including evaluation of cost-effectiveness of new and existing technologies combined with strategies to target resources to cost-effective care, increasing the cost of preventive care, the use of preventive care; identifying and increasing the use of cost-effective preventive care and high cost case management strategies.

Payment reform and development of purchasing strategies that promote the consistent delivery of care in efficient and appropriate settings; and administrative cost saving strategies, including development of effective information technology infrastructure. HSAs and high deductible are not the easy answer to what ails the U.S. health care system. Unfortunately, there is no easy answer, but there are promising strategies that are worth devoting our attention and resources to.

Thank you very much and I welcome your questions.

[The prepared statement of Linda Blumberg follows:]

Prepared Statement of Linda J. Blumberg, Ph.D., Principal Research Associate, The Urban Institute

Mr. Chairman, Mr. Camp, and distinguished Members of the Subcommittee: Thank you for inviting me to share my views on Health Savings Accounts (HSAs) and their implications for cost containment and the distribution of health care financing burdens. The views I express are mine alone and should not be attributed to the Urban Institute, its trustees, or its funders.

In brief, my main points are the following:

- The related issues of a large and growing number of uninsured Americans and the escalating cost of medical care create problems of limited access to necessary medical care for millions of Americans, financial hardship for many households, and severe budgetary pressures on the public health care safety net

as well as on Federal and State government. However, HSAs are not the solutions to these pressing national concerns.

- HSAs provide additional subsidies to the people most likely to purchase health insurance even in the absence of no subsidy at all—those with high incomes. As income and marginal tax rates increase, the value of the tax exemption associated with contributions to HSAs and the interest, dividends, and capital gains earned on HSA balances grows as well. Because most of the uninsured have low incomes and get little or no value from tax exemptions, the subsidies are very poorly targeted for expanding coverage.
- Because of the highly skewed nature of health care spending—the highest-spending 10 percent of the population accounts for 70 percent of total health expenditures—cost containment strategies that do not deal substantially with the high users of health care services will not have a significant effect on overall spending. The cost saving potential of HSAs is on spending before the deductible is reached, and most of health care spending occurs by high users of services, after the deductibles are reached. This significantly limits the ability of HSAs to lower systemwide health care spending.
- To the extent that high-deductible plans raise costs for higher-cost users, their use of medical services may fall. But there are no provisions to help these patients choose the services most important to their health, so reductions in care could lead to expensive, catastrophic health consequences in the long run. Moreover, patients' ability to compare health care providers on the basis of cost and quality is extremely limited. As a consequence, high-deductible plans and HSAs have a limited ability to make patients better value shoppers.
- Because high-deductible plans with or without HSAs place greater financial burdens on frequent users of medical care than do comprehensive policies (policies with lower out-of-pocket maximums and possibly broader sets of covered benefits), they tend to attract healthier enrollees. This selection can raise costs for the less healthy. The higher-cost insured population remaining in comprehensive coverage will tend to see their premiums rise as the healthy peel off into high-deductible/HSA plans. Unless the costs of these high users of care are spread more broadly by manipulating premiums across plan types or through regulation or subsidization, this dynamic will make coverage less affordable for those with the greatest medical needs.
- Despite lower premiums compared with comprehensive plans, high-deductible/HSA plans have so far failed to attract many low-income uninsured individuals and families. In addition to the fact that they get little tax benefit, they often do not have assets to cover the high deductibles—and have decided that they are better off remaining uninsured. The "one size fits all" high-deductible policy under the HSA legislation is flawed since, for example, a $2,200 deductible could be financially ruinous for a low-income family, while the same deductible could have virtually no cost-containment impact for a high-income family.
- Roughly half of those with HSA-compatible, high-deductible policies do not open HSAs (GAO 2008), despite the tax advantages of doing so. Two-thirds of employers offering single coverage through high-deductible/HSA combinations report making no contribution to the HSAs of their workers (Kaiser Family Foundation/Health Research and Education Trust 2007). As a consequence, low-income or high health-care-need workers with no choice of coverage but a high-deductible/HSA plan are likely to be exposed to much larger out-of-pocket financial burdens than they would be under a comprehensive policy, since employers are not, by and large, offsetting these higher deductibles with cash contributions to HSAs. Presented with the option of making varying contributions to HSAs as a function of worker income or health status, employers are highly unlikely to do so.
- At present, the legal use of HSAs is far more tax favored than is any other health or retirement account. Contributions, earnings, and withdrawals for HSAs can be tax free, if spending is health related. However, there is no mechanism in place, other than being subjected to a general tax audit, to verify that spending out of HSA balances is actually being done for medical purposes. Medical Flexible Spending Accounts (FSAs), a much more widely used tax-advantaged account for paying out-of-pocket medical costs, do have verification mechanisms in place that add very little to the costs of the plans. H.R. 5917 would prevent the illegal use of HSAs as a general tool of tax evasion.

Background

Between 2000 and 2006, employer-based health insurance premiums grew by 86 percent, compared with 20 percent for worker earnings and 18 percent for overall inflation (Kaiser Family Foundation and Health Research and Educational Trust

2006). By 2006, the number of uninsured had increased to 18 percent of the total non-elderly population in the United States, and a third of the non-elderly population with incomes below 200 percent of the Federal poverty level were uninsured (Holahan and Cook 2007). Health Savings Accounts have been one approach some policymakers have embraced to addressing these dual and growing problems.

While high-deductible plans have been available in the nongroup market for many years, the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) included provisions to provide a generous tax incentive for certain individuals to seek out high-deductible health insurance policies with particular characteristics. In 2008, the minimum annual deductibles for these policies are $1,100 for single and $2,200 for family policies. Annual out-of-pocket maximums for these plans are capped at $5,600 for single policies and $11,200 for family policies, with the limits applying only to the types of services included in the coverage of the plan.

Individuals (and families) buying these policies either through their employers or independently in the private nongroup insurance market can make tax-deductible contributions into an HSA. Funds deposited into the accounts are deducted from income for tax purposes, and any earnings on the funds accrue tax free, and are not taxed as long as they are used to cover medical costs. Contributions can be made by employers, individuals, or both. In 2006, Congress removed the requirement that annual deposits into HSAs be capped at the level of the plan's deductible, and instead provided a fixed statutory limit for annual contributions. In 2008, these limits are $2,900 for single policies and $5,800 for family policies.

HSAs were intended to encourage more cost-conscious spending by placing more of the health care financing burden on the users of services, as opposed to having them incorporated in the shared financing inherent in insurance coverage.

What Makes HSAs Attractive?

As a consequence of the structure of the tax subsidy and the shift of health care spending to out-of-pocket costs, these accounts are most attractive to high-income people and those with low expected health care expenses. The tax subsidy provided for HSA participants is greatest for those in the highest marginal tax bracket and is of little or no value to those who do not owe income tax. Clemans-Cope (forthcoming) demonstrated that 70 percent of the non-elderly uninsured have family incomes below 200 percent of the Federal poverty level, and that only 16 percent of uninsured adults fall into the 20 percent or greater marginal tax bracket. A $5,800 HSA contribution, the maximum permitted under the law, would generate a tax reduction of $2,030 to a household in the top income tax bracket. The value of the tax benefit would be less than half as much for a moderate-income family. And it would be worth much less if the family could not afford to contribute very much into the account. For those whose incomes are so low that they have no income tax liability, the subsidy is worth nothing. However, HSA contributions made by an employer, as opposed to by an individual, will decrease even a low-income worker's payroll tax liability, resulting in a modest tax savings.

Higher-income individuals are also better able to cover the costs of a high deductible, should significant medical expenses be incurred. Jacobs and Claxton (2008) showed that uninsured households have substantially lower assets than do the insured. As a consequence, high-deductible policies are unlikely to provide the uninsured with sufficient financial access to medical care in the event of illness or injury.

Additionally, those who do not expect to have much in the way of health expenses will be attracted to HSAs by the ability to accrue funds tax free that they can use for a broad array of health-related expenses that are not reimbursable by insurance (e.g., non-prescription medications, eyeglasses, cosmetic surgery). Those without substantial health care needs may also be attracted to HSAs because they can be effectively used as an additional IRA, with no penalty applied if the funds are spent for non-health-related purposes after age 65. Young, healthy individuals may even choose to use employer contributions to their HSAs for current non-health-related expenses, after paying a 10 percent penalty and income taxes on the funds—a perk unavailable to those enrolled in traditional comprehensive insurance plans.

These expectations have been borne out in the enrollment experience of HSAs (United States General Accountability Office [US GAO] 2008). The GAO analysis found that the average adjusted gross income of HSA participants was about $139,000 in 2005, compared with $57,000 for all other tax filers. They also found that average contributions to HSAs were more than double the average withdrawals, suggesting that either HSA participants were not high users of medical services or they used these accounts purely as investment vehicles—or both.

The incentive structure and the findings strongly indicate that HSAs and their associated tax subsidies are health care spending vehicles that are poorly targeted

to the population most in need—the low-income and those with above average medical needs.

The Cost Containment Implications of the Health Care Spending Distribution

The distribution of health care spending is highly skewed, meaning a small percentage of the population accounts for a large share of total health care spending. The top 10 percent of health care spenders spend 70 percent of health care dollars, while the bottom 50 percent of spenders account for only 3 percent of those dollars (Berk and Monheit 2001). As a consequence, significantly decreasing health care spending will require substantially lowering the spending associated with high users of medical services, ideally, while not decreasing quality of care. However, the high-deductible/HSA plan approach is not well designed for lowering the spending of the high-cost population in a manner that does not negatively affect their health.

Cost savings can be manifest through two mechanisms: a decline in the amount of services per episode of care due to an increase in marginal price, or through a decline in the number of episodes of care due to an increase in the average price. For those who are generally healthy and would not have annual spending that exceeded the high deductibles associated with HSA compatible plans, the increased marginal price of out-of-pocket medical care could have some impact on their use (Newhouse 1993, 2004). Incentives to curtail unnecessary services are strongest for these individuals. However, our analysis of the Medical Expenditure Panel Survey—Household Component showed that only 3 percent of total health care spending is attributable to those who spend below the minimum required deductibles. Consequently, there is little room for systemwide cost savings among this population since their spending accounts for so little of the overall expenditures.

For those who are unhealthy and who, with comprehensive insurance coverage, would spend above these higher deductibles, a number of scenarios are possible. Those who do not face significantly higher out-of-pocket maximums relative to their previous plan would not have any additional cost containment incentives. Those who face significantly higher out-of-pocket maximums under the new high-deductible/HSA plans would face a higher average price of medical care, and could reduce their spending as a consequence. However, research has demonstrated that the reductions in their spending would occur as a consequence of their reducing the number of episodes of their care, as opposed to reducing the cost of an episode once initiated (Newhouse 1993, 2004). In other words, they would decide not to initiate a contact with a medical professional for financial reasons, with potentially serious consequences for their health and for the long-term costs of their care. Two studies (Fronstin and Collins 2005; Davis et al. 2005) have found that HSA participants were more likely to report missed or delayed health services and not filling prescriptions due to cost. These problems were greater for those with lower incomes or worse health.

Paradoxically, high-cost individuals are not likely to curtail unnecessary services before reaching the high deductible, as might be desired. That is because the lion's share (80 percent) of health care spending for high-cost users of care is attributable to their spending that is incurred once those higher deductible levels are surpassed (Clemans-Cope forthcoming).

Since most of the current system's spending results from high-cost users spending above the HSA-compatible deductible levels, the cost-saving incentives can only affect a small segment of total health care dollars. That is unless the increased cost sharing is so much higher as to strongly dissuade the unhealthy from seeking much of the services that they would use under other circumstances. The health consequences of the latter could be extraordinarily grave, and the long-term cost consequences of allowing conditions to worsen substantially before care is sought may offset the cost saving from decreasing their early care.

While a number of studies have found that modest one-time savings of between 4 to 15 percent might be anticipated from conversion to high-deductible/HSA plans, they do not imply that such a change would have a significant impact on the rate of growth of medical spending. This is because medical spending growth is driven largely by the increased use of, and intensity of, technologies and services for people with high health care needs (Newhouse 2004). So while increased cost sharing can be used to lower the frequency of health care provider visits, it does not lower the costs per episode once an episode of care occurs.

Other, more promising avenues exist for achieving significant cost savings in our health care system. These include, among others,

- coordinated approaches to evaluation of cost-effectiveness and efficacy of new and existing technologies/procedures/medications combined with new regulatory and pricing strategies to target resources to the most cost-effective options;

- increasing the use of preventive care and chronic-care or high-cost case management strategies;
- payment reform and development of purchasing strategies that promote the consistent delivery of care in the most efficient and appropriate setting;
- administrative cost-saving strategies, including development of effective information technology infrastructure.

While many of these avenues require significant upfront investment in infrastructure, research, analysis, or experimentation, they are substantially more likely to yield systemwide savings without compromising access to and quality of care for the high-need population.

Implications of HSAs for the High Medical Need Population

The most significant premium savings accruing to high-deductible/HSA plan enrollees likely occurs by altering the mix of individuals who purchase coverage of different types. By providing incentives for healthy individuals and groups to purchase HSA-compatible plans, insurance risk pools can be further segmented by health status. The average medical costs of those purchasing the HSA plans will be substantially lower if the high-risk population is left in more traditional comprehensive plans. As the average cost of those in the comprehensive plans increases, so does the premium associated with the coverage. In the extreme risk segmentation circumstance, premiums for comprehensive coverage may increase so much that maintaining that type of coverage is no longer financially viable.

Such a circumstance can be avoided in the employment context if both high-deductible and comprehensive options are offered and employers set premiums for each plan independent of the health care risk of those enrolling in each. In other words, premiums for the high-deductible/HSA plan could be set such that they are lower than the comprehensive plan, but only due to the difference in actuarial value across the plans, not due to the differential health care risk of those enrolling in each plan. In essence, each plan's premium would be set as if all employees were enrolled in each plan. Then, a portion of premium collections for the high-deductible/HSA plan could be transferred to the comprehensive plan to subsidize premiums for that higher-cost group. In the nongroup market context, however, the transfer of financial support from the healthy to the less healthy will only occur through regulation or through direct government subsidization.

Without some type of intervention, by government or employers to spread health care risk more broadly, the practical effect of high-deductible/HSA plans is that the most vulnerable populations (the sick and low-income) are left bearing a greater burden of their health expenses. The extent to which this is a preferred societal outcome should be explicitly debated, as it is the primary impact of a move toward high-deductible/HSA plans.

The Ability of Patients to Be Good Value Shoppers

Theoretically, placing a greater share of the health care financing burden on the individual users of health care should create incentives for greater price/quality comparisons and more cost effective medical decisions. However, the ability of the patients to engage in such comparison shopping is extremely limited in the current private insurance context. As Ginsburg (2007) describes, effective comparison of services on price occur only in the context of non-emergency care, services that are not complex, bundled prices for services, consistent quality across providers, and only after an appropriate diagnosis has been made. Situations that meet such criteria eliminate a great deal of the medical care within the system. In addition, confidentiality agreements between providers and insurers prevent the providers from being able to give patients actual prices, as opposed to ranges that are generally not useful for comparison purposes. Traditionally, patients have relied upon their insurers to guide their provider decisions by choosing an efficient provider network on their behalf.

Enforcement of HSA Legal Requirements

As noted earlier, spending by those under 65 years of age out of HSA accounts is tax advantaged only if that spending is for medical purposes. If HSA funds are used for nonmedical purposes, a non-elderly individual would be required to pay taxes on the withdrawal in addition to a 10 percent penalty. However, currently, there is no administrative mechanism in place to verify that spending from HSAs is in fact being used for medical purposes. Unless an individual HSA participant is subjected to an IRS audit, there are no checks on the type of spending being done. Given that any individual's likelihood of an audit is very low, this lack of verification creates an easy mechanism for evading taxes. This problem is amplified

by the increase in allowable annual contributions to HSAs and the fact that such contributions can now exceed the associated insurance plan's annual deductible.

Flexible spending accounts (FSAs) are employment-related accounts that allow users to deposit pretax dollars into accounts that can then be drawn down during the year to pay for medical expenses. The permissible medical expenses are defined broadly, including out-of-pocket costs for care that is or is not part of the account-holder's insurance policy, just like HSAs. There are a number of differences between FSAs and HSAs (e.g., unused FSA balances are forfeited at the end of the year, they do not earn income, and they do not require health insurance plan participation), but the only relevant difference for this discussion is that withdrawals from FSAs are verified by the account administrators to be medical-related expenses that comply with the FSA law. This is precisely the type of verification that should be required of HSA withdrawals, and would be under H.R. 5917.

The insurance industry complains that imposing such verification on HSAs would eliminate their cost saving potential by imposing new and onerous administrative costs. However, the administrative costs of FSAs, which would be directly comparable with that of HSAs for this purpose, are actually very low. In fact, overall FSA administrative costs, which include payment of claims (a function which HSAs already perform and is included in their current administrative costs) as well as verification of the appropriateness of claims, are about $5.25 per member per month ($63 per member per year).[1] However, much of the administrative tasks associated with FSAs are not applicable to HSAs, and the cost of adding adjudication of claims to the HSAs would be about $2 per member per month according to the third party administrator of such plans that we contacted. If an additional cost of $24 per member would substantially reduce or eliminate the cost savings associated with HSAs, as some contend, then that is clear evidence that there is currently little to no cost savings associated with participating in those plans today.

Such an increment to administrative costs associated with these plans is clearly a very small price to pay to ensure that the law is being complied with and individuals are not using HSAs merely as a personal tax dodge.

Conclusion

HSAs are a highly tax-advantaged savings vehicle that is most attractive to people with high incomes and those with low expected use of health care services. As such, they are unlikely to significantly decrease the number of uninsured, who often have low incomes and neither benefit significantly from the tax advantages nor have the assets necessary to cover the large deductibles associated with the plans. Their ability to reduce systemwide spending is also very limited. The plans have the potential to increase segmentation of health care risk in private insurance markets, unless employers set premiums to offset the healthier selection into the plans or government subsidizes the higher costs associated with the remaining comprehensive coverage market.

To date, HSAs have been less popular than their advocates envisioned, making up only about 2 percent of the health insurance market (US GAO 2008). Thus, their negative ramifications on populations with high medical needs have probably been limited. However, efforts to expand enrollment in these plans through further tax incentives, for example, could place growing financial burdens on those least able to absorb them, leading to increasing effective barriers to medical care for the low income and the sick and potentially increasing the net number of uninsured.

References

Berk, Marc and Alan Monheit. 2001. "The Concentration of Health Expenditures Revisited," *Health Affairs*, 20:204–213.

Clemans-Cope, Lisa. Forthcoming. "Short- and Long-term Effects of Health Savings Accounts." Working paper prepared for The Urban Institute—Brookings Institution Tax Policy Center.

Davis, K., Doty, M.M. and Ho, A. 2005. "How High Is Too High? Implications of High-Deductible Health Plans." The Commonwealth Fund, April.

Fronstin, Paul and S.R. Collins. 2005. "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute and the Commonwealth Fund, December.

Ginsburg, Paul B. 2007. **"Shopping For Price In Medical Care."** *Health Affairs*, March/April; 26(2): w208–w216.

[1] From personal communication with third party administrators providing administrative services for FSAs and consumer-directed health plans.

Holahan, John and Allison Cook. 2007. "Health Insurance Coverage in America: 2006 Data Update." Henry J. Kaiser Family Foundation. http://www.kff.org/uninsured/upload/2006_DATA%20_UPDATE.pdf, accessed May 12, 2008.

Jacobs, Paul D. and Gary Claxton. 2008. "Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans." *Health Affairs*. Web exclusive, April 15, 2008, pp. w214–w221.

Henry J. Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Survey of Employer-Sponsored Health Benefits, 2006. See http://www.kff.org/insurance/ehbs-archives.cfm.

Henry J. Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Survey of Employer-Sponsored Health Benefits, 2007. See http://www.kff.org/insurance/ehbs-archives.cfm.

Newhouse, J.P., 2004. "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs*. Volume 23(6): 107–113.

Newhouse, J.P. and the Insurance Experiment Group. 1993. *Free for All? Lessons from the Rand Health Insurance Experiment*. Cambridge, MA: Harvard University Press.

United States Government Accountability Office (US GAO). 2008. Health Savings Accounts: Participation Increased and Was More Common Among Individuals with Higher Incomes. April 1. GAO–08–474R.

Chairman STARK. Thank you very much.

Ms. Waxman, would you like to proceed?

STATEMENT OF JUDY WAXMAN, VICE PRESIDENT AND DIRECTOR OF HEALTH AND REPRODUCTIVE RIGHTS, NATIONAL WOMEN'S LAW CENTER

Ms. WAXMAN. Yes, good morning, Mr. Stark, Mr. Camp, and other Members of the Committee. Thank you for having me testify this morning.

The National Women's Law Center supports health reforms that will provide high quality, comprehensive and affordable health care for all. We are afraid, however, that health savings accounts and consumer-driven health care will do little to expand meaningful health insurance.

I want to start my testimony this morning by advising you to pay attention to what women have to tell you in this health reform discussion, and that is because women are the health care deciders in this country. Women make approximately 80 percent of the health care decisions for their families and six in ten women report that they assume the primary responsibility for picking the health plan for their families. So ignore us at your peril.

Other interesting things that you need to know about women's health care needs that affect this deliberation is that women do require more health care throughout their lives than men do, including regular visits to their reproductive health care providers. They have more trouble affording care because in general, they have lower incomes than men. Today, women with and without insurance have an "affordability gap." They have more medical debt already.

Now, let's look specifically at consumer-driven health care plans. I have seven reasons why I think that they will not expand meaningful health care coverage to women and their families: one, cost sharing under these plans is not really affordable for the women that do have lower incomes which is a large number of women.

Premiums, even though they are obviously lower for the high deductible health plans, account for just a fraction of the cost of the

insurance. The deductibles and the other out-of-pocket costs can counteract those lower premiums. A survey of non-group policies that we saw recently said that the average deductibles for HSA-eligible health plans are really considerably higher than the Federal minimums that are required.

Number two: Lower income women cannot fund their HSAs and employers may not do it either. Lower income women who by the way are disproportionately represented among the uninsured women are simply not likely to have the cash resources to adequately fund the account. And we've heard this already. This morning, employer surveys estimate that only about a half of firms that offer these plans do actually contribute anything to the HSA.

Number three, low income women will not benefit from the tax advantages of HSA. They don't have high enough tax liabilities to benefit from this kind of tax treatment.

Number four, consumer-driven health care plan premiums are often higher for women, particularly in the individual health care market. Forty States and the District of Columbia do allow insurers to charge premiums that take gender into account.

We looked at the individual market in both your district, Mr. Stark, and yours, Mr. Camp, and we found that in the California district nearly half the plans charged significantly more for women, simply because they were women. And, in the Michigan district, all did.

You may say, well that's because women are going to have maternity care coverage; and, yet, as you already mentioned, Mr. Stark, no. That's not really it. Only four of the plans we looked at even offered maternity coverage in the California group and none in the Michigan group offered maternity coverage.

Number five: Women are more likely than men to have chronic health care needs and therefore are at greater risk under a consumer-driven health care plan.

Number six: Consumer-driven health care, interestingly, sometimes provides incentives for women to use less cost-effective care and preventive care. We have already heard that some preventive care is excluded from the deductible, but excluding preventative services is only an option for the health plans.

The IRS defines what is preventive care for this purpose and it's really quite limited in its definition. So, for example, prescription drugs are almost all subject to the deductible even if they do operate in a preventive way: For instance, cholesterol reducing drugs do not count as preventative treatment.

A vast majority of American women use a form of contraception that can only be accessed with a prescription; and, so, during the high deductible period, almost all women in this country would actually be subject to paying the entire cost of contraceptives out-of-pocket. That obviously creates a barrier for lower income women.

Number seven, and we have touched on this, women who need pregnancy-related care will face significant challenges under this kind of plan. Most, if not all, of the individual market plans that are consumer-driven health care plans do not even cover maternity care at all. But, even if a plan does cover maternity care, it is almost always excluded from the deductible.

Now, a pregnancy takes 9 months, which means you're most likely crossing over 2 years and having to deal with 2 years of deductibles, compounding the issue. The costs are significant and may even force some women to forego prenatal care.

In conclusion, health savings accounts and consumer-driven health care are the wrong answer to the nation's health care crisis.

Thank you. I welcome your questions.

[The prepared statement of Judy Waxman follows:]

Prepared Statement of Judy Waxman, Vice President and Director of Health and Reproductive Rights, National Women's Law Center

The Center supports health reforms that provide high quality, comprehensive and affordable health coverage for all. Health Savings Accounts (HSAs) and Consumer Driven Health Care, however, do little to expand meaningful health insurance. They are the wrong answer to the country's health care crisis, and they will not benefit women.

Health Reform Matters for Women

When designing health reforms, women's concerns should be taken seriously for a number of reasons:

- Women make approximately 80 percent of health care decisions for their families;
- Six in ten women report that they assume primary responsibility for decisions about health insurance plans for their families;
- Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers;
- Women are more likely to have chronic conditions that necessitate continuous health care treatment;
- Women use more prescription drugs on average, and certain mental health problems affect twice as many women as men;
- Women have more trouble affording health care since they are generally poorer than men; and
- Women—regardless of whether they are insured or uninsured—are already more likely than men to report problems with accessing health care due to cost.

Consumer-Driven Health Care Won't Expand Meaningful Health Coverage to Women and Their Families

- Cost-sharing under consumer-driven health care is not affordable for lower-income women and their families.
- Lower-income women cannot fund their HSAs, and employers may not do it either.
- Lower-income women will not benefit from the tax advantages of HSAs.
- Consumer-driven health plan premiums are often higher for women in the individual health insurance market.
- Women, who are more likely than men to have greater-than-average health care needs, are at greater financial risk under a consumer-driven health plan.
- Consumer-driven health care provides an incentive for women to use less cost-effective and preventive care, especially if that care is not exempt from the deductible.
- Women who need pregnancy-related care will face significant challenges under a consumer-driven health care model.

Consumer-Driven Health Care Is the Wrong Solution for America's Health Care Crisis

- Consumer-driven health care is unlikely to reduce the number of uninsured Americans.
- Consumer-driven health care will do little to contain rising health care costs.

Chairman Stark, Ranking Member Camp, and Members of the Subcommittee on Health, thank you for the opportunity to testify today on behalf of the National Women's Law Center. For over 35 years the Center has worked to both advance and protect laws and public policies that benefit women and their families. As part of these efforts, the Center supports health reforms that provide high quality, comprehensive and affordable health coverage for all. Health Savings Accounts (HSAs) and Consumer Driven Health Care, however, do little to expand meaningful health

insurance. They are the wrong answer to the country's health care crisis, and they will not benefit women.

Health Reform Matters for Women

When designing health reforms, women's concerns should be taken seriously for a number of reasons. First, women have a major stake in decisions about health care for their entire families and they often play a significant role in the care that their children, spouses, or parents receive. According to the Department of Labor, women make approximately 80 percent of health care decisions for their families.[1] Also, six in ten women report that they assume primary responsibility for decisions about health insurance plans for their families.[2] An even greater proportion, nearly 80 percent, chooses their child's doctor.[3] More women than men care for a family member—most often a parent—who is chronically ill, disabled, or elderly and in this role they typically provide assistance with medical finances such as bills or insurance paperwork and with making decisions about medical care.[4]

Women's characteristics and distinct health care needs—which are different from men's—should be taken into account when developing strategies to change the health care system. Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers. They are more likely to have chronic conditions that necessitate continuous health care treatment.[5] They also use more prescription drugs on average, and certain mental health problems affect twice as many women as men.[6,7]

Women have more trouble affording health care since they are poorer than men, in general. Roughly 57 percent of the adults living in poverty (i.e. with incomes below 100 percent of the Federal poverty level) are women.[8] In 2004, the median earnings of female workers (aged 15 and older) were $22,224, compared to $32,486 for men. Among full-time workers, women earn only 76.5 cents for every dollar men earn.[9]

Greater health care needs, combined with a disadvantaged economic status, make it particularly difficult for many women to afford health services. Women—regardless of whether they are insured or uninsured—are already more likely than men to report problems with accessing health care due to cost.[10] They spend a greater share of their income on out-of-pocket medical costs than men, and are more likely to avoid needed health care because of cost. In 2005, for example, nearly a third of non-elderly women reported that they did not fill a prescription because of cost, compared to just 18 percent of men.[11] Finally, uninsured and insured women alike are significantly more likely than their male counterparts to have medical bill and debt problems.[12] It is clear that many women, both the uninsured and the insured, are already struggling to afford the health care that they need. Health coverage plans that shift more of the costs of medical care to women and their families will only make this situation worse.

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[1] Department of Labor, General Facts on Women and Job Based Health (2008), available at http://www.dol.gov/ebsa/newsroom/fshlth5.html (last visited May 12, 2008).

[2] Alina Salganicoff et al., Women's Health in the United States: Health Coverage and Access to Care (2002), The Henry J Kaiser Family Foundation, available at http://www.kff.org/womenshealth/20020507a-index.cfm (last visited May 12, 2008).

[3] Alina Salganicoff et al., Women and Health Care: A National Profile (2005), The Henry J Kaiser Family Foundation, available at http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf (last visited May 12, 2008). [Hereafter "A National Profile (2005)"].

[4] *Ibid*.

[5] A National Profile (2005), *supra* note 3.

[6] Elizabeth Patchias and Judy Waxman, Women and Health Coverage: The Affordability Gap (2007), National Women's Law Center. An issue brief prepared for the Commonwealth Fund, available at http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf (last visited May 12, 2008). [Hereafter "The Affordability Gap (2007)"].

[7] National Women's Law Center and Oregon Health and Science University, Making the Grade on Women's Health: A National and State-by-State Report Card (2004).

[8] National Women's Law Center calculations based on U.S. Census Bureau, "Table POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2005, Below 100% of Poverty—All Races." Current Population Survey Annual Demographic Survey March Supplement, (2006), available at: http://pubdb3.census.gov/macro/032006/pov/new01_100_01.htm (last visited May 12, 2008).

[9] National Women's Law Center calculations based on U.S. Census Bureau Current Population Survey 2004 Poverty Tables, available at http://pubdb3.census.gov/macro/032005/pov/toc.htm (last visited May 12, 2008).

[10] The Affordability Gap (2007), *supra* note 7.

[11] *Ibid*.

[12] *Ibid*.

Consumer-Driven Health Care Won't Expand Meaningful Health Coverage to Women and Their Families

Cost-sharing under consumer-driven health care is not affordable for lower-income women and their families. Women have lower incomes than men and they typically need and use more health services. If health coverage is to be meaningful for women, it must be affordable. Consumer-driven health plans, however, require levels of cost-sharing that are prohibitively high for many women and their families. It is true that premiums for the HSA-eligible high-deductible health plans (HDHPs) are typically lower than premiums for traditional coverage, leading HSA supporters to claim that consumer-driven health plans will be more affordable for the low-income uninsured.[13,14] But, premiums account for just a fraction of the cost of insurance, and higher deductibles and other forms of out-of-pocket spending invariably counteract lower HDHP premiums. To open an HSA in 2008, individuals must be enrolled in a HDHP with an annual deductible of at least $1,100 for an individual or $2,200 for a family.[15] Policies sold in the insurance market tend to have even higher deductibles than the regulations specify. A survey of nongroup policies found that the average deductibles for HSA- and medical savings account (MSA)-qualified plans in 2006–07 were $2,905 for individual and $5,329 for family coverage.[16] Moreover, out-of-pocket spending does not stop at the deductible even after a high deductible is met, health insurance policies typically require additional cost-sharing in the form of co-payments and coinsurance.

Because women's greater health care needs and rates of use, combined with lower income, lead them to have higher out-of-pocket costs as a share of their income, more women than men are already "underinsured" (16 percent versus 9 percent).[17] The underinsured are those who are enrolled in an insurance plan that provides inadequate financial protection against catastrophic healthcare expenses. In 2003, about 12 percent of Americans were underinsured, and were almost as likely as the uninsured to go without needed medical care and incur medical debt.[18] Consumer-driven health care, by exposing the insured to even greater out-of-pocket medical costs, has the potential to contribute to the growing problem of underinsurance among Americans, particularly low-income women and their families.

Lower-income women cannot fund their HSAs, and employers may not do it either. In theory, out-of-pocket medical costs can be paid from a woman's tax-advantaged HSA, but lower-income women (who are disproportionately represented among uninsured women) are not likely to have the cash resources to adequately fund the account. In fact, many women enrolled in a consumer-driven health plan have to forgo opening an HSA altogether. In the years 2005 through 2007, close to half of all HSA-eligible plan enrollees did not even open an HSA.[19] In other words, these individuals and families had the high deductible, but not the tax-advantaged account that is supposed to help make that high deductible affordable. While employer HSA contributions could help spread the burden of out-of-pocket medical costs, employer surveys estimate that roughly half of small and large firms offering HSA-eligible health plans for families do not contribute anything to their employees' HSAs.[20]

Lower-income women will not benefit from the tax advantages of HSAs. Most lower-income women and families do not face high enough tax liability to benefit in any significant way from the HSA tax arrangement. HSA tax breaks selectively reward richer Americans, and a very poor family with no taxable income would not benefit from a tax deduction at all. Deposits to an HSA account reduce

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[13] U.S. White House, State of the Union: Affordable and Accessible Health Care (2006), available at http://www.whitehouse.gov/news/releases/2006/01/20060131-7.html (last visited May 6, 2008).

[14] U.S. Department of Treasury, Health Savings Accounts (2008), available at http://www.ustreas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf (last visited May 6, 2008).

[15] *Ibid*.

[16] America's Health Insurance Plans, Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits (2007), available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf (last visited May 12, 2008).

[17] The Affordability Gap, 2007, *supra* note 7.

[18] Cathy Schoen, Michelle M Doty, Sara R Collins, and Alyssa L Holmgren, Insured But Not Protected: How Many Adults Are Underinsured?, Health Affairs Web Exclusive (2005). W5-289–W5-302. Underinsured adults include continuously insured individuals who satisfied one of three conditions: annual out-of-pocket medical expenses amounting to 10 percent or more of income among low-income adults, out-of-pocket medical expenses amount to 5 percent or more of income or health plan deductibles equal or exceeding 5 percent of income.

[19] U.S. Government Accountability Office, Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes (2008). GAO–08–474R.

[20] *Ibid*.

a participant's taxable income by the amount of the contribution—since tax rates increase as income increases, the deduction is a better deal for the more affluent. Reports on the income level of HSA accountholders support this notion non-elderly tax filers who reported HSA activity in 2005 had an average adjusted gross income of about $139,000, compared to about $57,000 for other filers.[21] Furthermore, though HSAs were designed to be used as a tax-saving method to accumulate funds for health care expenses in retirement, some evidence suggests that these accounts are more often being used as tax shelters by higher-income individuals.[22]

Consumer-driven health plan premiums are often higher for women in the individual health insurance market. If a woman decides to purchase a consumer-driven health plan in the non-group insurance market, she will likely encounter an additional barrier to affordability. Many women who purchase an HSA-qualified health plan in this market are charged a higher monthly premium than their male counterparts for the exact same benefit package, solely because they are female. Indeed, insurers are allowed to consider gender when setting non-group health insurance rates in 40 States and the District of Columbia, including the home States of both Chairman Stark and Ranking Member Camp. Our research indicates that a 34-year-old female constituent in the California's 13th District (represented by Chairman Stark) who is seeking a non-group HSA-qualified health plan would be charged between 4 and 45 percent more than a male peer for nearly half of the plans available to her. If she were living in Michigan's 4th District (represented by Ranking Member Camp), that same woman would be charged more than a male peer for every non-group plan available to her—she would pay between 15 and 48 percent more for the exact same benefit plan. One might assume that these premium disparities are based on the fact that, unlike their male counterparts, women of childbearing age can make insurance claims for maternity care. However, most non-group HDHP policies do not cover maternity benefits at all. Of the 18 HDHP plans available to a 34-year-old woman in the California district, just four offered some type of maternity coverage, and none of the 34 plans available in the Michigan district covered pregnancy-related care.[23]

Women, who are more likely than men to have greater-than-average health care needs, are at greater financial risk under a consumer-driven health plan. Women are more likely than men to have a chronic condition that requires ongoing treatment, and even healthy women use more health care than men. If health insurance is to be meaningful for women, it must cover the services that they need without exposing them to significant financial risk. However, those who need the most health care—including women with disabilities and chronic conditions—are most likely to struggle to meet increased cost-sharing requirements of high-deductible health plans. These individuals often experience higher medical costs and are more likely to spend amounts up to their deductible each year. Healthy people with very low medical expenses, on the other hand, are especially advantaged under an HSA arrangement since their HDHP premiums are lower than under traditional insurance plans and they pay trivial out-of-pocket amounts.

Consumer-driven health care provides an incentive for women to use less cost-effective and preventive care, especially if that care is not exempt from the deductible. Consumer-driven health care also has implications for women's preventive health service use. Because consumer-driven health plans shift more costs to the insured, they provide an incentive to use less (and therefore spend less) on health care. HSA guidelines do permit certain preventive services to be exempt from the deductible, but this is a voluntary option for health plans. In a 2007 survey, more than 50 percent of individuals enrolled in an HSA-qualified health plan reported that their deductible applied to all health care services, including preventive care.[24] Moreover, prescription drugs—even those that serve a preventive rather than treatment purpose—are generally not exempt from a deductible.[25]

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[21] *Ibid*.

[22] Edwin Park and Robert Greenstein, GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals (2006). Center on Budget and Policy Priorities, available at http://www.cbpp.org/9-20-06health.htm (last visited May 12, 2008).

[23] Independent analyses carried out by National Women's Law Center (2008), using information from www.ehealthinsurance.com on HSA-qualified health plans for women residing in zip codes 94538 (Fremont/Alameda, California) and 48640 (Midland, Michigan).

[24] Paul Fronstin and Sara R Collins, Issue Brief No. 315: Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey (2008), The Employee Benefits Research Institute, available at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3897 (last visited May 12, 2008). [Hereafter "2007 Consumerism in Health Care Survey"].

[25] A survey of insurers offering consumer-driven health plans found that less than 6 percent of these plans included coverage for prescription drugs as a preventive, exempt benefit. See: Association for Health Insurance Plans, A Survey of Preventive Benefits in Health Savings Ac-

The majority of American women use a form of contraception that can only be accessed with a prescription. In the year 2002, for example, 82 percent of women aged 15–44 who had ever had sexual intercourse reported that they had used the oral contraceptive pill.[26] Women who use a prescription drug for family planning would be responsible for the full cost of their birth control under a consumer-driven health plan. This presents a cost-related barrier to service use, especially for lower-income women.

Participating in an HSA/HDHP could have a negative impact on women's health if they delay or go without necessary care because they cannot afford to meet the high deductible. Poor women and their families, who have less income to contribute to an HSA and may not have enough funds in their accounts to cover their health care needs in a given year, would be particularly vulnerable to this harmful consequence. A recent survey found that, compared to those enrolled in more comprehensive plans, consumer-driven health plan enrollees were significantly more likely to avoid, skip or delay necessary health care or medications because of the cost.[27] Indeed, this type of plan aims to discourage utilization of unnecessary health care, but increased cost-sharing has the potential to discourage the use of cost-effective and necessary preventive care at the same time. The landmark RAND Health Insurance Experiment demonstrated that greater out-of-pocket spending requirements reduced costs by encouraging patients to use less health care—including necessary care that is strongly supported by evidence.[28] A more recent study of rates of biennial breast-cancer screenings in Medicare plans with different levels of cost-sharing for mammography demonstrated that even nominal copayments were associated with significantly lower screening rates compared to plans with full coverage. These effects of cost-sharing were magnified among women living in lower-income areas.[29]

Women who need pregnancy-related care will face significant challenges under a consumer-driven health care model. In particular, consumer-driven health care has specific consequences for maternity care, one of the most common and costly medical interventions that women of reproductive age will experience. Pregnant women enrolled in a consumer-driven plan might be exposed to high out-of-pocket costs, particularly when complications arise. As demonstrated in our research on the health plans available in two districts in California and Michigan, most individual HDHP policies exclude coverage for normal maternity care altogether, so that expenses for these services would not even count towards the deductible. For plans that do cover maternity care, unlike other preventive services such as well child-care, prenatal care is typically subject to a HSA-qualified deductible, and this significant cost-sharing might keep some women from obtaining prenatal care services. Nine-month pregnancies tend to span two insurance plan contract years and so may be subject to two annual deductibles, compounding the issue. A 2007 study demonstrated the range in out-of-pocket maternity care costs that women could face under several different consumer-driven health plan options—from a low of $3,000 for an uncomplicated pregnancy with vaginal delivery to a high of $21,194 for a complicated pregnancy with a Cesarean section delivery.[30]

Consumer-Driven Health Care Is the Wrong Solution for America's Health Care Crisis

In addition to the problems that HDHP/HSA arrangements pose for individual women and their families, this strategy is unlikely to deliver on its promise to help solve America's health care crisis.

Consumer-driven health care will do little to contain rising health care costs. Most of America's health care costs are incurred by only a small percentage of very sick or injured individuals, for expensive treatments related to major illnesses or end-of-life care. The cost of this care exceeds the high deductibles required

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count (HSA) Plans, July 2007 (2007), available at http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf (last visited May 12, 2008).

[26] William D. Mosher, et al., "Use of Contraception and Use of Family Planning Services in the United States: 1982–2002," Advance Data From Vital & Health Statistics No. 350, at 15 (2004).

[27] 2007 Consumerism in Health Care Survey, *supra* note 25.

[28] Joseph P Newhouse, Free for All? Lessons from the Rand Health Experiment, Insurance Experiment Group (Cambridge, MA: Harvard University Press 1993).

[29] Amal Trivedi, William Rakowski and John Z Ayanian, Effect of Cost Sharing on Screening Mammography in Medicare Health Plans (2008), New England Journal of Medicine 358(4):375–83.

[30] Karen Pollitz et al. *Maternity Care and Consumer-Driven Health Plans* (2007), a Report for the Henry J Kaiser Family Foundation, available at http://www.kff.org/womenshealth/upload/7636.pdf (last visited May 12, 2008).

under HSAs and would still be paid for by the health plans. Simply put, HSA arrangements won't contain those high-end expenditures. For example, one study found that only 21 percent of total health spending falls below the minimum deductible level for an HSA-eligible health plan.[31] Additionally, if consumer-driven plans disproportionately attract healthier and wealthier individuals—as research demonstrates they have done[32]—sicker and poorer Americans will be concentrated in traditional, comprehensive insurance plans. This segments the pool of insured lives, so that risk is no longer spread between those with high and low medical expenditures—as a result, premiums for those in traditional plans will be driven even higher. A recent actuarial study of six large employers who offered both consumer-driven and more traditional health plan options to their workforce found that, indeed, a disproportionately younger and healthier population selected the consumer-driven option. Notably, most of the reduction in health costs that these employers experienced under the consumer-driven health plan option could be attributed to the more favorable risk profile of the workers enrolled in that type of plan.[33]

Consumer-driven health care is also unlikely to reduce the number of uninsured Americans. A 2004 analysis indicated that HSAs would be used predominately by people who are already insured, and that gains in coverage would be offset by the loss due to employers canceling insurance on the assumption that the availability of new subsidies makes employment-based coverage unnecessary. Analysts estimate that HSAs could in fact increase the number of Americans lacking health insurance.[34] Additionally, in 2006 nearly two-thirds of the non-elderly uninsured were poor or near-poor, with incomes at or below 200 percent of the Federal poverty level (which was $40,000 for a family of four in that year).[35] These lower-income families are unlikely to have the resources to participate in a health plan with high levels of cost-sharing. A recent study found that among households with at least one uninsured member, less than half had sufficient gross financial assets to meet the minimum HSA-related deductible.[36] Furthermore, since many lower-income families earn too little to have any tax liability, coverage proposals which rely on tax deductions—such as the HSA initiative—will have little impact on the low-income uninsured. So far, research on consumer-driven plans confirms this notion, since surveys of plan enrollees in both 2006 and 2007 found that adults in this type of plan were no more likely to have been uninsured prior to enrollment in their plans than those enrolled in traditional coverage plans.[37]

Conclusion

As a growing number of national and state leaders move forward to address the failing health care system, there have never been so many opportunities to ensure that women have access to the health care they need. In order to address the challenges that women face in getting health care for themselves and for their family members, health reform strategies must include policies that will help women and their families obtain meaningful health insurance. Coverage that provides the most comprehensive benefits at the most affordable cost will go the farthest to improve women's health and financial security, but consumer-driven health care plans do not fit this description. Instead, the mechanics of HSA/HDHP arrangements shift much of the risk of needing expensive care from employers and insurers to women and their families. This can deter financially concerned enrollees from getting medically necessary care when they need it, and those with higher-than-average medical expenditures—including women—may take on significant financial risk. Moreover, contrary to the claims of their proponents, strategies that rely on consumer-driven health care do little to address two major and interrelated problems with the American health care system—the increasing ranks of the uninsured and rising health care costs. Health Savings Accounts, and consumer-driven health care in general, are not an acceptable answer to the nation's health care crisis.

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[31] Linda Blumberg and Leonard Burman, Most Household's Medical Expenses Exceed HSA Deductibles (2004), Tax Notes.

[32] 2007 Consumerism in Health Care Survey, *supra* note 25.

[33] Jack Burke and Rob Pipich, Consumer-Driven Impact Study (2008), a Milliman Research Report, available at http://www.milliman.com/expertise/healthcare/publications/rr/consumer-driven-impact-study-RR04-01-08.php (last visited May 12, 2008).

[34] Edwin Park and Robert Greenstein, Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of the Uninsured (2004), Center on Budget and Policy Priorities, available at http://www.cbpp.org/5-10-04health.htm (last visited May 12, 2008).

[35] Henry J Kaiser Family Foundation, Distribution of the Nonelderly Uninsured by Federal Poverty Level, 2006 (2008), available at www.statehealthfacts.org (last visited May 11, 2008).

[36] Paul D Jacobs and Gary Claxton, Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans (2008), Health Affairs web exclusive, available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.3.w214 (last visited May 6, 2008).

[37] 2007 Consumerism in Health Care Survey, *supra* note 25.

Thank you for this opportunity to testify. I welcome your questions.

Chairman STARK. Thank you.
Mr. Sensor.

STATEMENT OF WAYNE SENSOR, CEO, ALEGENT HEALTH, OMAHA, NEBRASKA

Mr. SENSOR. Good morning, Mr. Chairman, and Members of the Committee.

I, too, thank you for this opportunity to share our story, the story of Alegent Health and our journey to engage people more readily in their health care.

I will acknowledge as I start my testimony today that certainly some of the other panelists and some Members of this very Committee have expressed concerns about consumer-driven health care and particularly high deductible plans. And I would quickly say in a few minutes that I will chat with you formally today.

I will attempt to create the construct that it's not just about the high deductible vehicle, the HSA or HRA, but far more powerful is the benefit plan and the construct, the environment that encourages the right behavior that we choose to wrap around those vehicles.

I also testified to you today in an unusual position in that I represent both a provider and a very large employer, which gives me the opportunity to assure that we have an environment where information is readily available and people can and do make informed decisions. Alegent Health in a nutshell is a not-for-profit faith-based provider of health care with nine acute-care hospitals. We provide care at 101 cites across eastern Nebraska and western Iowa. We have 1,300 physicians and just shy of 9,000 employees in our current configuration.

Three years ago, we began a journey, a journey to engage people more readily in their health and their health care decisions and we decided that the natural starting point for that journey was our own workforce, the 9,000 men and women of Alegent Health. And so we began to design a plan, which took largely the better part of a year, and to communicate that plan, and to educate our workforce as to a new way to look at health care.

The results I'll tease you with have been nothing short of exceptional. Fully loaded, our costs have increased an average of 5.1 percent over each of the last 2 years, 37 percent less than the national average. Voluntarily, 92 percent of my workforce that currently uses our insurance program uses one of our four consumer-driven health plans, 92 percent.

Let me speak quickly to the journey that brought us to this point in time and then more granularly as to our results. As we began to think about a new way of looking at health care we began to populate our Petri dish, if you will, with our own workforce. It became apparent that this is indeed a very complex issue we're facing and that it would take the right incentives that would be a right benefit plan; that it would take the right tools that would be meaningful quality and cost information.

What other good or service do we buy in this country where you do so in a complete vacuum relative to cost and quality?

And, thirdly, that it would require new and creative access points that are cost efficient, convenient, and predictable. I'll speak briefly to each of those points. Our new benefit plan to HSAs and to HRAs now including 92 percent of our workforce has two constructs that are really the meat, if you will, around the plan.

The first is if it's preventative care and indicated for your age cohort it is free—no deductible—no co-pay—everything from annual physicals, mammographies, colonoscopies, child immunizations. We want our workforce to utilize those services.

Secondly, we have a program called healthy rewards, which directly incentivizes individuals to make lifestyle changes the single, greatest determinant as to how much health care you'll consume in your life. Everything from managing your chronic illness to weight loss to smoking cessation, incentivizing people with direct dollars to make lifestyle changes to live healthier and consume less health care.

The second major construct that I would say change is required and in the air is people must simply have tools to make decisions about their health care. Three years ago, we began publishing our quality scores that were alluded to in Congressman Camp's opening remarks. We also have a cost-estimating tool on-line so you can see what it will actually cost you for your care.

The third and final leg of this stool to really look at health care differently is access. People need choices. People need choices that are cost-efficient, that are high quality, and that are predictable. We have opened our seventh walk-in clinic and grocery stores—10-minute turn-around time—$24 to $52.

Sixteen percent of the people that attend or go to that site for care express that they have no health insurance. The results on our HSAs, relative to our workforce, have been phenomenal. While I shared the aggregate results a moment ago relative to our HSAs during the last 2 years, we have seen a full 15-percent decline in the cost of care for those individuals.

In the HSA, we are now spending 9 percent of our total dollars on prevention versus 2.3 percent as a national average. Ninety-six percent of the people participating in our HSA now use generic drugs as their choice when they are available. Ninety-eight percent of our HSA participants regularly contribute to their HSA via payroll deduction. Thirty-two percent have already fully funded their deductible as part of their HSA. And, even more piercing, people earning $25,000 or less are funding an average of $1,400 into their HSA.

I would conclude, Mr. Chairman and Committee Members, HSAs and HRAs are a wonderful tool. They will single-handedly not fix health care in America. I believe that people given choice, people given relevant information, and people incentivized to make the right decision can and will do so and it will raise the quality of their care and will indeed reduce costs.

Thank you very much and I welcome your questions.

[The prepared statement of Wayne Sensor follows:]

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Wayne Sensor
CEO Alegent Health
Testimony
Ways and Means Health Subcommittee
May 14, 2008

Good morning Mr. Chairman and thank you for the opportunity to give a brief overview of Alegent Health's experiences with consumer-driven health care. While I recognize that many of you have concerns about high-deductible plans, I would submit that we've had tremendous success with our plans because of the benefits we've wrapped around our HRA and HSA vehicles. And, because we are both an employer and provider of care, I believe we have a unique story to tell. I ask that my full statement be entered into the record.

Alegent Health is a faith-based, not-for-profit health care system that serves eastern Nebraska and western Iowa. Our 9,000 employees and 1,300 physicians are proud of the care we provide in our 9 hospitals and more than 100 sites of service. Each year we serve more than 310,000 patients.

In fact, Alegent Health is the largest non-governmental employer in Nebraska. And we have a very powerful story to tell about the benefits of consumer driven health care and are positioned very distinctively in the ongoing debate.

Alegent Health's story begins in 2004. I was the newly-appointed CEO for Alegent Health, and along with the senior leadership team, we recognized that troubling industry-wide trends were beginning to threaten our ability to carry out our critical mission. Rapid escalation in the number of uninsured patients, unsustainable increases in the cost of health care and other concerning trends were undermining the accessibility, quality and affordability of health care.

Armed with this information, the Alegent Health leadership team embarked on an effort to better understand the forces behind this gathering storm in health care and develop lasting solutions. The result was a fundamental change in thinking about the roles and responsibilities of both health care providers and consumers. We at Alegent Health recognized that to overcome problems clouding the future of the industry, the process of delivering health care at the local level could no longer be business as usual.

In examining the issues facing the health care industry, we soon recognized that the very nature of the third-party payor system was a significant contributor to the problems. By shifting payment responsibilities from patients to insurers, the incentive for patients to analyze the value of care they received had all but

disappeared. Even more significantly, the tools that would allow consumers to compare health care quality and cost were virtually non-existent.

To begin changing this dynamic, we drew upon our new strategic plan, known as the Quality Revolution. Our vision is to become a world-class leader in health care by measurably enriching the lives of families we serve through an exceptional commitment to quality. Our strategic plan includes an objective to put consumers at the center of the health care equation by empowering them to take charge of their own health and make informed decisions.

We began our journey to greater consumer involvement in health care when we made a commitment to begin empowering consumers. In early 2005, we began to explore how a health care program could improve the lives of employees and their families while offering sustainable business solutions. The research exposed widespread frustration over the existing benefits package, but also raised concerns that employees would view consumer-driven health care as a reduction in benefits. Elsewhere, consumer-driven plans were already beginning to earn a reputation as a means of cost shifting from employers to employees.

To counter these perceptions, we engaged nationally known health plan designers Watson Wyatt and Lumenos, a leading provider of consumer-driven health plans. We spent a year designing our consumer directed health plans and communicating with our employees what the change would mean to them.

The results have been exceptional:

- As we enter our third plan year, 92 percent of employees who choose our health care benefits have enrolled in either an HSA or HRA plan.
- It is important to note that we did not force employees into a consumer directed health plan. We continue to offer a PPO for employees.

Furthermore, communication was key to the process. We wrapped our innovative plans in robust, ongoing, multi-channel communication and education for our employees, answering their questions, working with them one-on-one, hosting conference calls and benefits fairs and developing Web modeling tools. The effort was critical to share our vision that the consumer-driven plans were about employee health – and not our bottom line. We never intended to save money with our new plans; instead we hoped to slow the growth of future increases in cost.

In pioneering the new benefit plan, Alegent identified three overriding areas where we knew as an employer and provider we could tremendously advance consumer directed health care. The areas are:

- Incentives to encourage preventive care, lifestyle change and management of chronic health conditions

- Tools to make informed decisions in the form of meaningful cost and quality information;
- Access points for care that are innovative, convenient and cost-effective

Incentives for Preventive Care/Lifestyle Change/Chronic Disease management

HRAs and HSAs are valuable vehicles, but in my view it's what you wrap around those vehicles that make a powerful difference.

There are two important constructs in Alegent Health's consumer driven plans. First, preventative care is free. This ranges from services like annual physicals, and mammographies to childhood immunizations and colonoscopies. If it is preventative, it is free.

And second, through an innovative "Healthy Rewards" program, we pay people to make positive changes in their lifestyles, or to better manage their chronic conditions. And, we offer that assistance free of charge – free weight loss counseling, smoking cessation programs and chronic disease management. For those who need a little extra support, we offer free personal health coaches. If an employee quits smoking, takes a personal health assessment, loses weight or makes other positive changes that affect their lifestyle, Alegent Health deposits money directly into their health savings account.

Tools to Facilitate Cost and Quality Transparency

Giving our employees more control required us to make dramatic changes.

First and foremost, we created tools to provide meaningful and relevant cost and quality information. What other good or service do people purchase in this country without knowing how good it is and how much it costs?

In September 2005, well before we were required to do so by law, we began publicly reporting our quality data and, using a composite scoring methodology, shared our performance in the care of heart attacks, heart failure and pneumonia. At that time, our scores were not always the highest. However, our focus on transparency drove us to raise the bar on quality and sent our scores increasingly higher.

- Our quality reporting goes well beyond Hospital Quality Alliance's 21 measures. We currently report 30 measures – the CMS 20 and 10 SCIP measures. We will be adding an additional 10 stroke measures beginning July 1 this year.
- To give these scores some context we show how Alegent Health compares to our regional competitors as well as the premier institutions' like the Mayo Clinic, Cleveland Clinical, and Johns Hopkins.

I'm proud to report our quality is as good as or better than our local competitors and the elite facilities mentioned.

Transparency is a difference maker!

Composite Scores

	AMI	HF	PN	Overall
2005	90%	79%	87%	88%
2007	99%	98%	99%	99%

We didn't stop by just sharing quality information. In January 2007, we introduced a cost estimating tool – My Cost – which is the first of its kind in the world.

Alegent Health's approach to cost transparency is even more customized for the consumer. This on-line tool called My Cost provides consumers with the information they need, based on their individual health plan or personal financial situation. It determines the specific costs of the procedure or test to individuals, along with their out-of-pocket costs for more than 500 common medical tests and procedures.

By working with a third party insurance database, My Cost is able to verify insurance policies, deductibles, and provide patients an extremely accurate price estimate on more than 500 medical tests and procedures. In 16 months it has provided nearly 35,000 individuals – employees and members of our community – with estimated cost and out-of-pocket responsibilities for medical services.

As the CEO of a health care provider, I understand the arguments against providing transparency on cost and quality and I reject them. Alegent Health is proof that you can share cost and quality information and not only be competitive, but excel in your marketplace.

Access

Finally, Alegent Health believes it necessary to give consumers more choice in how they access our services. We must follow the lead of nearly every other industry that has told consumers they can "have it their way." We must radically alter our thinking about where care can and should be provided. While we will always need hospitals to care for the most critically ill, we must continue to pioneer new access points for patients, offering convenient, cost-effective care.

With an emerging retail strategy that offers consumers walk-in clinics located in grocery stores, we have worked with our physician staff to create clinics that offer families easily accessible, low cost and medically sound care for basic illnesses.

Here's how it works: the clinic is open from 9 a.m. to 7:30 p.m. Monday through Friday and from 10 a.m. to 3 p.m. on weekends and holidays. A patient signs in at the Alegent Health Quick Care office and waits his or her turn. In keeping with the streamlined service, the cost for each service is posted at the clinic where cash, checks and credit cards are accepted for payment. Prices range from $25 to $53 depending on the service. Our patients love it. It's quick. It's convenient. They know exactly what they are going to pay.

- One exceptional benefit to these clinics is that we found 16% of customers who visit the clinics are uninsured patients who otherwise might have forgone care or waited until the ear ache or sore throat required a trip to the emergency room.

In addition to our convenient Quick Care clinics, we are implementing innovative, more comprehensive solutions to healthcare through our retail strategy.

Our first storefront – Complete Sleep & More – offers a line of leading-edge products designed to improve the quality of sleep through traditional clinical methods and lifestyle enhancements. A second component of our retail strategy includes expanding our already well-respected pharmacy services to our patients and physicians in a way that provides a superior customer experience, differentiates ourselves from "chain" pharmacies and creates deeper patient loyalty.

Results

We now have results from our first two years of consumer-driven health plans for our employees, and we are astounded at the results. Over our first two years, we saw an average increase in our healthcare costs of just 5.1%, despite industry trends in the 10-15% range. Moreover, our employees are healthier.

- Nearly 7% of Alegent Health's health care dollar is spent on prevention, compared to the national average of 2.5%.
- Forty percent of employees participated in an electronic health checkup program, each earning $100 for their efforts.
- Alegent Health identified 15% of employees who could benefit from personal health coaches. Of these, 3.3 percent enrolled in the program, and 91% of them have graduated successfully, earning financial incentives up to $500.
- More than 500 health plan participants successfully completed smoking cessation programs.
- Participants in our weight loss programs have lost nearly 13,000 pounds.

When we implemented the health plans on January 1, 2006, Alegent Health's leadership pledged that if employees could achieve a collective improvement in health and slow rapidly rising costs, some of the savings would be returned to them. After the first plan year, Alegent Health did, in fact, return $700,000 in the

form of $100 rebates to every employee in the health plans because of the significant cost savings achieved. It was a way for Alegent to reinforce that we did not move to a consumer directed model to save money "on employees' backs", rather we made the transition because we believe it is the model that will dramatically alter how we Americans think about and consume health care.

Digging a bit deeper into results from our two HSA plans – those we would consider pure consumer-driven plans – there is a significantly higher level of engagement among those participants and the results are event greater.

- They consume more preventive care than any other plan we offer.
- More than 45% of HSA participants completed their health risk assessments, compared to just 16 % in our PPO plan.
- Nearly 65% of pharmacy prescriptions for HSA participants were filled with generic drugs, compared to 56% in the PPO plan.

This level of engagement clearly has significant implications for the health of these employees. We have seen a dramatic decrease in costs. From 2006 to 2007, the cost trend in our two HSA plans declined a full 15%!

And, to those who say people are putting off care or not adequately preparing for a future healthcare need, we can refute that as well.

- One hundred twenty employees who make less than $25,000 have chosen an HSA plan; only 97 employees who make more than $100,000 have chosen an HSA plan.
- More than 80 percent of our employees in the HSA plans made regular contributions to their HSAs, and 32% have fully funded their deductibles.
- Perhaps most impressive is the fact that our lower wage earning employees -- those who make less than $25,000 per --year contributed an average of $1400 to their HSAs last year.

Alegent Health's commitment to innovation and to empowering consumers to make informed health care decisions calls for us to look beyond the region in which we operate and offer our expertise to providers from across the country. We believe inviting consumers into the decision process about their health care will dramatically improve health care quality and lower costs. We have proven this with our own workforce and the people we serve and we want to share our roadmap to price and quality transparency.

Alegent Health has taken its learnings and offered to share them with other providers, in the hopes of accelerating consumer behaviors in health care. In January of this year, we hosted a not-for-profit educational forum designed to help other health care organizations develop the systems and policies to provide consumers the necessary information to make more informed decisions about their care. Using Alegent's own experiences with providing easily understood health care quality scores and personally relevant pricing information, the "Power to the Patient" forum shared Alegent's proprietary methodology and technology

developments to the nine health care system that attended. In the future we hope to replicate this effort and continuing sharing our success with any interested parties that chose to attend...

These results we have offered are proof that given the benefit plan, tools and incentives, people can AND DO make informed health care decisions that improve their health and lower their costs. Alegent Health believes in consumer-directed health care and we are happy to have shared with you these tangible examples of how these constructs can and do work just as we have shared them with other interested parties across the country.

Thank you.

Chairman STARK. Thank you all very much.

I guess, Dr. Chernew, help me with this one. From an economist's view, if you were ill, very ill, and knew it, diabetes or something that required constant and probably expensive medical care, and you've had a chance to buy a plan with a $700 deductible, but your premium was only reduced by $480, you'd be inclined to not take, wouldn't you?

Mr. CHERNEW. Generally speaking, that would be right.

Chairman STARK. Yeah. Now I think that Mr. Sensor's plans are almost even, as much information as we can get on them, that your decrease in premium about matches the increase in the deductible. So I don't know what you'd do there. I mean I imagine that it's more a matter of convenience, if you just leave the savings account thing aside, if you're just trying to save money by getting a higher deductible if you knew you were going to need a lot of treatment and could make that decision rationally, I don't know what you do where it's a match. I guess there again it would be convenience, and what you were used to doing if you were the kind of person who could save money and have it available, or if it was helpful for you to pay monthly.

Another thing that I think it was Dr. Blumberg who suggested that 10 percent of the population spends 70 percent of the costs that we spend on medical care. And I used to think of it as 20 percent and 80 percent of the cost; but either way.

But help me with this. I'm an employer and I got 100 employees. And let's just say for the hell of it that I was to going to get them a high deductible plan, a $3,000 deductible, let's say. And it would be the same premium whether they signed up for a savings account or not. It's just a high deductible plan. Well, if I put 3,000 bucks in every employee's health savings account, and I had 100 employees—I did this with my shoes and socks on, I want you to know—I'd spend 300,000 bucks over and above the premium, right?

Ms. BLUMBERG. That's right.

Chairman STARK. But if I self-insured, when I said to you as my employee, "I'll pay for any covered benefit. I'll pay the deductible until you get up, and I take the risk." I'm fussing around here, and with your numbers, I don't see I get much above $100,000 if everything turned against me.

Ms. BLUMBERG. I'm sorry. I didn't follow where the $100,000 is that you'd end up spending on the ill you're talking about.

Chairman STARK. Yeah. Because if 10 percent of my employees use up 70 percent of the cost, that leaves 90 percent of my employees with the rest of it, I can't get that number to get much above 100 grand. Now my stockholders would be disappointed in me, I suspect, if I gave all these hardworking folks the $3,000, when I could get away giving them the same benefits by only spending a little more than $100,000. Does that make some sense to you?

Ms. BLUMBERG. That is essentially the difference between the HSAs and the HRAs, in that with the HRAs the money is really held by the employer; it doesn't become——

Chairman STARK. Well, even if it's not even held, just the employer self-insures for the deductible. And then gets the savings of the high deductible. And it would depend on whether you got an old workforce or a young workforce. But I have always been puz-

zled—and you know, I'd sure hate to go to the auto dealer who's loading up, paying 100 percent of the savings accounts, when the dealer down the street has got my plan. I get a better deal on my Ford or Chevy or Toyota, I'll bet you. But that's just a matter that I've always been puzzled by as a person who used to hire people, which is what we did. We just paid the deductible and it seemed to be a good plan, and saved us a lot of money.

Mr. Dicken, do you have any indication of what's currently going on in terms of how many of the high-deductible plans also get savings accounts?

Mr. DICKEN. Right. As has been reported as of January 2008, there are about 6 million Americans that have the high-deductible health plan. But——

Chairman STARK. How many? This is 2008?

Mr. DICKEN. As of January 2008 it's been reported by an insurance carrier survey. But——

Chairman STARK. How many, 6 million have it?

Mr. DICKEN. Six million have the high-deductible plan, but not all of those have the savings account that's associated with it. Blue Cross studies, a nationally representative study as of 2007, indicated about 49 percent of those with high-deductible health plans did not have the associated savings account.

Chairman STARK. Okay. So a higher percentage if you take those figures now have a savings account associated with the plan that had in 2005.

Mr. DICKEN. Yeah. Blue Cross has shown a small increase. It's ranged from about 40 or 50 percent that they've found from 2005 through 2007.

Chairman STARK. And did you have any figures on how many of those were self-funded and how many were employer-funded?

Mr. DICKEN. There has been a change. From 2005 through 2007, a larger share of the high-deductible health plans are employer-based or group-based, rather than individual. There is still data that not all employers are contributing to the health savings account. Some industry estimates and employer surveys indicate that among the large employers, maybe about two-thirds of employers are contributing and less among smaller employers.

Chairman STARK. And that's a higher number than you had in 2005?

Mr. DICKEN. Those data among the employer benefit surveys have been generally in the same ballpark.

Chairman STARK. Mr. Camp?

Mr. CAMP. All right. Thank you, Mr. Chairman.

Mr. Sensor, you mentioned that you have 9,000 employees at Alegent, and they have a choice of whether to stay in their PPO or enroll in an HSA. And I believe I heard your testimony that 92 percent of your employees elected an HSA. Can you tell me something about your employees, what percentage are women? Do you know their average income? And why might 92 percent of your employees made that choice?

Mr. SENSOR. Thank you very much. A couple thoughts. First of all, I think 92 percent chose because we spent a year communicating and educating around an exceptionally well-planned benefit plan. I think people chose it because it makes sense for them.

The breakdown of 17 percent are in HSA, 75 percent are in HRAs, and 8 percent remain in the PPO.

Mr. CAMP. What percentage are women, do you know?

Mr. SENSOR. Eighty-two point five percent of our workforce are women, and there is no stratification relative to which plans. It's about equal. They don't have a preference.

Mr. CAMP. Do you know the average income of your employees of that group that's chosen?

Mr. SENSOR. I mean there are some interesting anomalies when you look at the dispersement or stratification by income. A full 50 percent of the individuals that have chosen the HSA, arguably that which puts the most risk on the employee, 50 percent of those individuals earn $50,000 or less. In addition to that I might add quickly that of the individuals making $25,000 or less, they're actually contributing quite handsomely to their HSA at about $1,400 a year.

Mr. CAMP. At incomes of $25,000 and less, about $1,400 a year. What's the difference in the premium cost between the high deductible plan and the PPO that you offer your employees?

Mr. SENSOR. It's a substantial difference, as Chairman commented on his opening remarks. Again, we planned our benefit very, very carefully to incent the right behaviors. And so the punch line is: You can largely entirely fund your HSA out of your premium savings. Plus, of course, you get free preventative care and incentives to live a healthier lifestyle or manage your chronic care.

The specific answer is a family plan PPO would have premiums of $426 a month. The highest-risk HSA would have premiums of $24 a month, and the more moderate HSA about $200 a month. So the more moderate HSA is half of what the PPO would be for family coverage.

Mr. CAMP. Now can you just talk about some criticism of—high deductible plans certainly don't take into account all the extra initiatives you offer in your plan, including the incentives for changing health behaviors and wellness. Can you just talk about those? And if you believe if other plans offered those, that that might address some of the criticisms we've heard?

Mr. SENSOR. Well, I'm obviously a very strong proponent in preventative care. The research is replete and clear. We don't do enough of it in this country, and we ought to incentivize Americans to practice more preventative care.

The second item that you referenced was what we affectionately call "healthy rewards," that directly incentivizes individuals to address high-risk factors. That could be everything from the obvious. That would be weight loss, smoking, use of tobacco, or it could be less obvious, and that would be managing your chronic health care problem outside of acute episodes, your diabetes, your chronic asthma, et cetera.

We have a whole plethora of resources that are brought to bear to assist those individuals. All of those resources are free, from Weight Watchers, the patches, and the gum, all the way to personal health coaches, who telephonically assist you in completing a program that will reduce your risk factor.

And then at the conclusion of one of those programs, two, three, four, or five hundred additionally will drop into your HSA on top of the amount that the employer has already contributed.

Mr. CAMP. Now you offer both high deductible plans and a PPO. Now typically services related to normal pregnancy and childbirth are not covered in the individual market, are they? Unless mandated by the State?

Mr. SENSOR. I think that would be typically, yes.

Mr. CAMP. So that in that sense, high deductible plans in the individual market aren't any different than other individual market plans?

Mr. SENSOR. I think that would be a fair conclusion.

Mr. CAMP. All right.

I'd also like to submit to the record testimony from the March of Dimes Foundation to that effect, without objection.

Chairman STARK. Without objection.

Mr. CAMP. Now again, I just want to comment—I see my time's running out—that again some of the official testimony we've had the second year a program worth only 1 million filers, used as a benchmark, comparing HSA filers to all tax filers, not tax filers with insurance. And I would ask Mr. Dicken, if you could get to me a comparison of HSA filers with other filers with insurance, I think that information might be helpful to the Committee. It may be different; it may not.

And also again your analysis left out HSA holders without any account activity. So with that, I see my time's expired. Thank you, Mr. Chairman.

Mr. BECERRA. Thank you, Mr. Camp.

I'm going to go ahead and inquire—and hopefully by the time I complete my questioning, Chairman Stark will be back, and if not I'll stay until he is back. And I'm not sure if Mr. McCrery has already voted.

Have you voted yet? Okay. So we'll see where we head with Members. But I suspect Chairman Stark will be back by the time I finish my inquiry.

Let me begin by asking Mr. Dicken a question. I believe, Dr. Blumberg, you mentioned that the accountability for HSAs is somewhat suspect. We have no real way to track how people are using HSA moneys other than what they provide to us, to the IRS to prove how they ended up using dollars deposited into the health savings account.

Mr. Dicken, can you tell us what IRS does to try to ensure that the money that's placed in an HSA and is therefore tax-deferred, is used for health activities?

Mr. DICKEN. Well, thank you. The information that is reported to IRS is self-reported by HSA accountholders as to whether they've used any withdrawals from their health savings account for qualified medical expenses or otherwise. We found in 2005 that tax filers reported that 93 percent of what they were reporting were for qualified medical expenses.

To the extent to which IRS can confirm that, depends on the extent to which they are conducting audits.

Mr. BECERRA. Are you aware of what the audit rate is for tax filers who have HSA accounts?

Mr. DICKEN. We don't know the specific amount; certainly for general audits, that's a fairly small share of tax filers and less than 1 percent of tax filers in 2005 were reporting HSA activity.

Mr. BECERRA. Are you aware of any activity on the part of IRS where they are intending to try to monitor the use in filing or recording purposes on HSAs by tax filers?

Mr. DICKEN. To the extent that IRS has done more targeted rather than general audits, we're not aware as to whether that's occurring or not.

Mr. BECERRA. So right now we know there is some $240 billion or more I think in taxes that are not paid by Americans and corporations, because for the most part it's based on self-attestation, or self-reporting by a number of individuals and corporations to pay their taxes. This HSA program right now relies on that same type of self-declaration on the part of the taxpayer who has an HSA account.

It is also correct that once you reach the age of 65, any money that you may have deposited into an HSA over the years as a taxpayer then becomes yours, tax-free, whether or not you use it for health-related activities?

Mr. DICKEN. Once you're 65 you can withdraw it without the penalty that otherwise accrues. Otherwise, if you're under 65 and taking out moneys for non-qualified medical expenses, then there would be a 10 percent penalty. So that 10 penalty doesn't apply; although it would be taxed as income otherwise, if it were——

Mr. BECERRA. This is sounding more and more like a really good tax shelter if you happen to have a good amount of money that you've already maxed out on your 401(k), you've maxed out on your IRA, you've maxed out on every other municipal bond that you could decide to invest in. And all of a sudden you now find that you have a pot of $5,800, or however much it will be in the future, that you could put money aside in, in an HSA, and so long as you stay healthy—and so far I've been pretty healthy—if I reach 65 and hardly use any of that money, I then after that point can use that money for unrelated health care purposes, and never paid Uncle Sam money that most average working Americans would not have been able to do.

Is there any way to track that type of activity by someone who is—and I think we've heard testimony that the wealthier you are, the more inclined you are to use an HSA, which means that we're placing folks who have the ability to pay for health insurance coverage in a pool where they get to save at the same time that they're the ones that are least likely to not want to have health insurance. It sounds to me like a Ponzi scheme here.

Mr. DICKEN. Well, the reliance right now is on the self-reporting by individuals of what they're using the funds for.

Mr. BECERRA. Okay. So that wasn't an answer that clarified how this isn't a really good way to try to shelter money from the IRS, where the average working American has to rely on an employer to provide health insurance.

Dr. Blumberg, let me ask you this. Do you have confidence? Is there a way for you to have confidence that the HSAs are being used for what they're intended to be used by all people?

Ms. BLUMBERG. I don't think there's any way we can have confidence in that, because there is no adjudication of the claims that are being drawn down out of the accounts. I mean we can rely on most people being honest, but other than that, we——

Mr. BECERRA. Are you aware of any process or system that the IRS is implementing to try to give us that confidence that HSAs won't be used as a tax shelter by those who can afford it? This sounds like trickle-down health care.

Ms. BLUMBERG. I don't know of any approaches that they're taking. What I do know is the approach that's taken for other tax-advantaged medical spending accounts that could be applied.

Mr. BECERRA. Like?

Ms. BLUMBERG. In the case of medical flexible spending accounts, which are a different type of structure in that they have some different rules. The dollars don't roll over from year to year. But they do have some of the same tax advantages within a given year for deposits. The claims on the medical flexible spending accounts are verified by third-party administrators who run those types of plans to verify that they've been used for medical purposes before the claims are paid out.

Mr. BECERRA. Mr. Sensor, Dr. Blumberg raised a good point. There are some plans that do require more reporting. My understanding is that most of your employees have applied for the HRA accounts. Do you with your HSA accounts require a reporting?

Mr. SENSOR. We do not require a reporting. We have debit cards that we use to pay our medical expenses, which of course creates a paper trail. Or you pay with a check. And parenthetically I might add, as I was filing my own personal income taxes this year, my accountant acknowledged that I had a rather large dispersement for medical bills. I got to use some of my own health care. And indeed, she asked if I could document using my debit card or my checks, what I'd use those expenses for. When I told her "Yes," she responded that upon audit I would be required to do so, and that that was between me and the IRS. I do feel like with my employees that we do have adequate documentation, should they be audited.

Mr. BECERRA. Yeah. And the operative word there is "should you be audited?" And the chances of being audited, given, as Mr. Dicken said, that there is a very small pool at this stage of folks, of tax filers who are using HSAs, and whether or not they would be audited is another question.

Again, I think all of us want to see Americans be covered; but from everything I'm hearing today, the pool of Americans who are uninsured, that 47 million universe of Americans, probably doesn't have enough money in their accounts or in their regular checking or the regular paycheck to be able to afford to put much money into any type of health savings account in the first place.

In the second place, when you do open one, we rely on people's good faith to report accurately what they use their money for, which is wow, as I said, I'd love to collect the, what is it?—it's either $240 or $340 billion that we know annually we don't collect in taxes, because people aren't reporting properly. And this just seems to be another avenue for those who have decided not to report properly to continue to do that. That type of trickle-down health care seems to be taking us in the wrong direction.

But I thank all of you for your wise testimony and appreciate your being here. Thank you, Mr. Chairman.

Chairman STARK. Thank you. I got all this time while everybody else goes to vote.

Let me come back, Mr. Sensor, just a couple of questions. I think you said 75 percent in an HRA. How much in an HSA? How many?

Mr. SENSOR. Seventeen percent.

Chairman STARK. Seventeen? And 8 percent in your PPO?

Mr. SENSOR. Correct.

Chairman STARK. But your PPO is frozen?

Mr. SENSOR. It's currently frozen, yes.

Chairman STARK. Why?

Mr. SENSOR. A couple reasons I would submit to you. First of all, we chose when we rolled out the plan not to force our employees into HSAs or HRAs, but rather to present the benefits and let them make their own choice. And as you can see, not very many chose the PPO.

We've seen decline in the latter 2 years, and determined that at such a small enrollment, 8 percent of my population, that it didn't make sense to continue to trickle a very few people when most people were abandoning. In fact, we've seen 10 percent migration into our HSA each of the last 2 years.

A couple other quick items relative to the efficacy of that 8 percent in our PPO. If it's risk that is the issue to the employee, our two HRA plans, which allow for Alegent to contribute either $1,000 or $2,000—and first dollar coverage comes directly out of therefore our money, not the employees—really blunt the level of risk, if that's the reason that an individual chose that option.

And lastly, but from a total out-of-pocket expense, we've done some analysis of all in, including premiums, including your co-pays, including your deductibles, where are my employees better off? And indeed that PPO option they spend considerably more dollars out of pocket in total than our HSAs. In fact, the gap is about $4,710 total cost out of pocket for a PPO participant versus $2,709 for the HSA.

Thank you.

Chairman STARK. Thank you. Is there a fixed dollar amount that you contribute to the HSA?

Mr. SENSOR. Yes. Our contribution is $100 to open the account.

Chairman STARK. $100 a year?

Mr. SENSOR. $100 a year, yes.

Chairman STARK. Wow. Give the store away with that, aren't you? Okay. And in the HRA, let me see if I understand what that—that sounds like the plan that I would have proposed. But basically, unused funds. Each employee has an account, right? How much goes into that account roughly each year?

Mr. SENSOR. If it's an HRA we're speaking to, it's between 1- to $2,000, depending on whether it's family coverage or not.

Chairman STARK. And that money can only be spent for covered benefits or proven health care?

Mr. SENSOR. Correct.

Chairman STARK. Okay. And the employee never gets their hands on it? Basically that's a bookkeeping entry that you control the funds and the dispersement thereof?

Mr. SENSOR. No. I would look at that a little differently. They have control over dispersement of those funds. They can't spend them personally.

Chairman STARK. Uh-uh. Right.

Mr. SENSOR. They choose, however——

Chairman STARK. And they can't buy a mutual fund with them, or——

Mr. SENSOR. Correct.

Chairman STARK. Okay. And you watch those a lot more closely than you watch the government money, don't you? That's interesting.

So and then when the employee leaves or dies or retires, anything that's left in that HRA account comes back to the company?

Mr. SENSOR. That would be correct. Since the company contributed those funds, the proceeds would return to Alegent.

Chairman STARK. Okay. So it's really kind of a self-insuring by your company for the deductible, isn't it?

With a cap.

Mr. SENSOR. Yeah. If I may, Mr. Chairman, I would position it as it's a transitional vehicle that's between a PPO and an HSA in that it gives people the ability to control how those dollars are spent. We still fund prevention, we still fund change of lifestyles, and reduction of risk, all of which flow into that account, all of which they determine how they'll use them. But the first——

Chairman STARK. But unlike an HSA, they can't spend it for college or keep it for retirement and spend it? That's your money.

Mr. SENSOR. Right.

Chairman STARK. And you're at risk for it.

Mr. SENSOR. Correct.

Chairman STARK. And somehow I think I'm going to get Dr. Chernew to suggest even if it is—I'm too greedy to make this discussion—but when it's my money, I am much more interested in how it's invested and how it gets used than if it's your money, and I'm off to Rite Aid, or whoever I want to go see, the cosmetic surgeon to get cleaned up a little around the edges. You know, what the hell? If it's not mine, I don't care; if it's mine I'm going to watch it much more carefully.

Okay. Could you talk to me, Dr. Chernew, about cost sharing under high deductible plans and health care quality? And I'm going to ask Dr. Blumberg to talk about this, too.

One of the things that I recall from my dim, dark past is that Kaiser, who is always half the people in my district belong to Kaiser—and they've always had a variety of fixed-rate $5, $10 co-pays for prescriptions or a visit to the—in some plans, and they vary from union to union—but they've always been in the neighborhood of $5 or $10. And I think that they said that they could deter overutilization, abuse of the plan just as well as the $5 or $10 amount, and the minute they went above that, all they found was that people were somewhat more reluctant to get needed medical care. In other words, for some very small amount you can get the hypochondriacs and sort them out. But once you get above that very much or go higher, you start to get people who make the decision not to get the prescription or the service.

So I'm going to ask—that's just something that I wonder if it still holds, but I'd like your thoughts, Professor Chernew, on what cost sharing, what effect you see that can have on quality.

Mr. CHERNEW. Thank you, Mr. Chairman. I guess my opinion is there is probably overuse of care along the entire spectrum, and if you charge people money, you'll reduce the amount of overuse. I think there's also needed care all along the spectrum, and if you charge people money, you will have them not consume care that's needed.

It's difficult to figure out exactly how you want to justify charging patients with diabetes for their blood pressure medication, or their diabetes medication, that is care that you know is needed. We've heard today that certain plans have incentives to prevent that type of thing, and I would support those incentives.

I think the challenge is to recognize that there is a lot of heterogeneity in the types of plans. So we need to think through when we look at the different plans how those plans really set up their cost-sharing for things that look like quality.

I think if we look broadly, the evidence is overwhelming that if we look at either standard measures of quality to "HEDIS" measures, or other measures of quality that people have thought of, like how well people are managing their chronic disease; that in situations where people have to pay more—and it's not always a ton more, a lot of the studies, $15 to $20, not a lot more—people don't take their blood pressure medication, they don't take their diabetes medication, they don't get some of the checkups that you think they might get if they have different illnesses.

So if we use our standard quality metrics, I think we would find, on average, not in all plans or for all people, but on average we would see worse quality if people were systematically charged more.

And I think that's a difficult argument to refute, based on sort of the broad peer reviewed literature.

Chairman STARK. Thank you. Sam, did you inquire?

Mr. MCCRERY. Not yet, no.

Chairman STARK. I don't what the—go ahead. Mr. McCrery, would you——

Mr. MCCRERY. I'll give Mr. Joseph a few minutes to gather his thoughts, since he just got back.

Chairman STARK. Okay.

Mr. MCCRERY. Thank you, Mr. Chairman.

I appreciate you're letting me inquire even though I'm not a Member of the Subcommittee. I guess I am ex-officio.

Chairman STARK. You certainly are.

Mr. MCCRERY. Dr.—and I'm sorry, I wasn't here for introductions—is it Chernew?

Mr. CHERNEW. Anyway you pronounce it's fine with me.

[Laughter.]

But yes.

Mr. MCCRERY. How do you pronounce it?

Mr. CHERNEW. Chernew.

Mr. MCCRERY. Chernew.

Mr. CHERNEW. Just as long as it's not Blumberg.

Mr. MCCRERY. Can you give us a list of the peer-reviewed literature on which you just based your generalization? That would be helpful.

Mr. CHERNEW. There's a great review of some of the studies. The drug studies were reviewed. I think they reviewed 923 articles and they found 132 that met their criteria. It's all summarized in a paper by Dana Goldman. It was in JAMA in 2007.

Mr. MCCRERY. Is that in your materials?

Mr. CHERNEW. It's referenced in my testimony. The article itself isn't in my testimony. There have been other reviews. I edit a journal called the American Journal of Managed Care. I would be happy to make it available to anyone in this room, actually for free, if they contact me.

But we get a series of submissions. We've published a peer review article by—the lead author is a woman named Theresa Gibson, that's also looked at this literature. There's a summary of results published in a book by Joe Newhouse called Free for All, looking at the results of the Rand Health Insurance experiment, that has some discussions of the role of cost-sharing. And they randomized individuals. And it's somewhat dated now; the study was done a few decades ago.

Mr. MCCRERY. Mm-hmm.

Mr. CHERNEW. And I can certainly tell you the studies that we have done. Our study on the impact of cost-sharing on disparities is coming out in the Journal of General Internal Medicine. It's online now.

So there's a lot of people. I apologize, I may not have cited some of Linda's work.

But I think the bottom line from all of this work is overwhelmingly people do cut back on care, as proponents of higher cost-sharing plans would want, as an economist would expect when you charge them more. The challenge has been in most cases they seem to cut back on appropriate and inappropriate care similarly.

Mr. MCCRERY. Well, I remember reading a summary of the Rand study some time ago, and I'd have to admit it's been quite some time since I've looked at it. But seemed to me they reached a contrary conclusion that in terms of health outcomes, the health outcomes didn't seem to be that adversely affected.

Mr. CHERNEW. So that is right. And I should say just for——

Mr. MCCRERY. That is right?

Mr. CHERNEW. Well, I should say that is——

Mr. MCCRERY. That is correct?

Mr. CHERNEW. First let me say that the lead author is a colleague of mine, Joe Newhouse, and I have spoken with him some about this point, in part prior to this. They found that on average there were not large health effects in those plans. They found that there was reductions in the use of needed care, and there were some adverse health consequences, particularly in people with chronic disease and people that were low income. They believe that some of the care that was cut out was care that was unnecessary, perhaps harmful, and so that was useful. And they believe some of the care that was cut out was care that really was needed care, and created problems.

I think the challenge is to understand particularly as we live in a world now where there's a lot greater chronic illness, a lot more medications for treating chronic illness, a lot of services that weren't available in the era of the Rand Health Insurance experiment to understand exactly how these things follow through.

And in studies that you've seen more recently, you do find a lot of evidence that in some of these particularly chronic care areas that people aren't doing the things that we want them to do, and we do believe there are adverse health consequences.

Let me add by saying, as I said in my testimony, as an economist, I am not philosophically opposed to cost sharing, and I believe their situations with cost sharing can work. I believe there are people that can manage it better than other people. I believe there are individuals and companies that can design it better than other individuals and companies.

So I am not inherently opposed in any way to this. That being said, I think there are areas where a general across-the-board HSA type plan or high-deductible type plan will cause real harm to some individuals in the way in which they manage the markets because of challenges for a whole slew of reasons in how folks manage their illness. And it seems that when they're faced with a higher price, not all of them, but some of them do a substantially worse job. And I think it's——

Mr. MCCRERY. I think that's a fair statement.

Mr. CHERNEW. And I think it's a challenge of trying to work——

Mr. MCCRERY. But I did want to get the other conclusion on the record, though, Mr. Chairman, that the Rand study in fact concluded generally that there wasn't a very distinct diminution in health outcomes as a result of increased cost sharing.

Chairman STARK. That was the Rand study done in the 1970s?

Mr. MCCRERY. I don't recall the date, it was several decades old.

Mr. CHERNEW. The data was collected in the mid-1970s. There were many publications, so there's probably still some going on. I'm not familiar with them, but the publications——

Mr. MCCRERY. But I don't think human has changed significantly since the 1970s.

Mr. CHERNEW. But the medical technology for which they need access to has.

Mr. MCCRERY. But we could get into a whole philosophical discussion about new medical technology and availability and affordability. I don't think this is the time or place for that. But it would be a nice discussion for us to have. And we're going to have to have that discussion at some point, Mr. Chairman.

Chairman STARK. All right.

Ms. Tubbs-Jones, would you like to inquire?

Ms. TUBBS-JONES. Yes, Mr. Chairman. Thank you very much. Good morning, ladies and gentlemen. How are you?

Mr. Sensor, can you tell me the racial makeup of your company?

Mr. SENSOR. I do not know that off the top of my head. I am so sorry. But I would be glad to send that to you electronically in followup.

Ms. TUBBS-JONES. It would be interesting, because you do know that there are health care disparities that fall among races.

Mr. SENSOR. Absolutely.

Ms. TUBBS-JONES. And for you to be able to really give me a clear sense of how well your company is going with that program, that is a factor that really would be useful for us.

And over this year of training or education that you did with your workers, it seemed to me that that might also be something that ought to be factored in the process of training. Can you tell me the income of the people that you have in your company?

Mr. SENSOR. The average hourly income is about $24.50. And that would be an aggregate number for all of our 9,000 employees.

Ms. TUBBS-JONES. And that's a pretty—that's a decent wage for—and so it would be safe to say that your folks are skilled?

Mr. SENSOR. We have a mixture of skilled and less skilled.

Ms. TUBBS-JONES. Mm-hmm. Thank you very much. I'd be interested in the information, particularly because health disparities, especially as it affects racial and ethnic minorities, is an important issue for me, as I try and make some decisions, or am involved in policymaking around health savings account and health—these accounts.

Mr. SENSOR. Absolutely. If I may, just one followup.

Ms. TUBBS-JONES. Oh, sure.

Mr. SENSOR. Thank you. We will provide that information in followup.

The personal health coaches that are made available free to all of our employees to deal with the risk factors would be able to speak more specifically to the unique health challenges of the different populace.

Ms. TUBBS-JONES. I mean because much of the studies have clearly shown that low-income and racial minorities tend to the ones that spend the least amount of health care, and come to the health care system with chronic and acute illnesses as a result of lack of preventive care. So I'd be interested in hearing that information.

Thank you.

Ms. Waxman, on behalf of the National Women's Lawyers Association. A former member, glad to have you here. I'm interested in what your studies have shown with regard to—well, we all know that most of the research around women's health didn't happen until women jumped up and down and acted crazy enough for them to begin to do some research around our issues.

But I'm interested in the impact that these types of savings accounts have on women's health, and when we affect women's health, we affect children's health as well. So I'm interested.

Ms. WAXMAN. Absolutely. There haven't been that many studies on the actual impact because they haven't really been in existence that long.

Ms. TUBBS-JONES. Maybe I should rephrase and say women's access to necessary health care.

Ms. WAXMAN. Yes. Well, the one issue I raised, and has come up a couple times, I think would be great to clarify about maternity care. Because yes, as I mentioned, it is not generally covered in the individual markets, certainly not in the HSA individual markets.

But even if it is covered in the plans, in the small group plans or the other plans, it is generally subjected to the deductible. So in other words, if you're in a traditional plan, maternity care's covered, you get it, your doctors——

Ms. TUBBS-JONES. I think if men had to have babies, it would be covered.

Ms. WAXMAN. Well, I mean the plan can choose to have the maternity care covered, called preventive care. But if it isn't, and most aren't, then you have to go through the deductible. So as I mentioned, 9 months often spans two insurance calendar years, and you have to meet the deductible twice. So a Kaiser study of last year concluded that women were going to be facing between 3- and $21,000 for their maternity care, even if it's covered. But you have to get through the deductible first. And that is obviously a significant problem for women trying to get their prenatal care, and may deter some women from doing so.

Ms. TUBBS-JONES. Sounds like the basis of a great lawsuit to me. And you know, let's think about whether or not we need to be looking at this discriminatory practice against women in the health care system. I know——

Ms. WAXMAN. There are a number of other issues we could discuss, which maybe we should do another time.

Ms. TUBBS-JONES. Less I be viewed as being a litigious Member of Congress.

Thank you very, very much.

Mr. Sensor, my staffer has given me one more thing. Do you contract out or directly employ your support staff, Mr. Sensor?

Mr. SENSOR. To the best of my knowledge, they are employed staff.

Ms. TUBBS-JONES. Okay.

Thank you very much, Mr. Chairman. Just for the record, I'd like to welcome my health LA to the Committee. Her name is Athena Abdullah. I'm looking forward to having her work with us.

Thank you very much——

Chairman STARK. I hope you'll explain to her that I'm exempt from lawsuits under these situations.

Ms. TUBBS-JONES. Well, you know, I'm not talking about you, Mr. Chairman. I'm talking about it's a real issue for women across this country, and sooner or later we're going to get our appropriate dues, since we take care of you men all the time.

Chairman STARK. Ah, and we appreciate it.

Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Dicken, health savings accounts were created in the 2003 Medicare bill. Do you know the year the product was first made available on the insurance market?

Mr. DICKEN. Yes. They were first available as of January 2004.

Mr. JOHNSON. 2004? So your 2008 report used the 2005 return information for your findings, is that correct?

Mr. DICKEN. The IRS data was for 2005, as the most recent data from the IRS.

Mr. JOHNSON. So the report only looked at the scope of the product during its first year on the market?

Mr. DICKEN. IRS data was for the first 2 years. We were also able to supplement that with other information from other industry sources and benefit surveys for 2006 and 2007.

Mr. JOHNSON. Okay. So you agree there's over 6 million individuals in the country with an HSA today?

Mr. DICKEN. There are over 6 million individuals with a high deductible health plan. There's a smaller group of those that have the health savings account.

Mr. JOHNSON. Okay. And 56 percent of them, I'm told, were opened in the last 18 months; 45 percent of HSA accountholders now have incomes less than $50,000. Is that true?

Mr. DICKEN. I think that's consistent with AHIP survey results, yes.

Mr. JOHNSON. Okay. Then do you believe your GAO report adequately describes the current situation?

Mr. DICKEN. I think we use the most recent and credible information, and so recognizing that the IRS data was just for the second year, tried to supplement that with other surveys for more recent years. But certainly it is a dynamic market in the early years of——

Mr. JOHNSON. Changes every day, doesn't it?

Mr. Sensor, in 2005, you decided to provide HSA as an option to your employees. Can you tell us again how many of your employees have chosen to enroll in the HSA option?

Mr. SENSOR. Seventeen percent of our employees are using that option.

Mr. JOHNSON. Do you have an HSA personally?

Mr. SENSOR. I do.

Mr. JOHNSON. Wonderful. Some have argued that the high deductible health plans do not offer any advantages for the low-income workers, because they don't have the resources to fund an HSA. What steps have you taken to provide additional help for your low-income workers?

Mr. SENSOR. As a faith-based, not-for profit, we are exceptionally sensitive to the lower income employees, who I could argue are an important backbone in health care these days. If an individual earns less than $14.42 an hour, we subsidize their premium. In essence, we pay for their insurance. Secondarily, we have an incredibly gracious charity care policy. We extend our charity care policy to 400 percent of the national poverty guidelines, using the HUD guidelines. And certainly that would relate to my employees as well if they were unable to pay their portion of that payment.

And last but not least, I mentioned walk-in clinics as yet one more solution from an access standpoint; $24 to $52 and 16 percent of the individuals that walk through those doors indicate they have no health insurance, and I think some of my employees find that as a viable alternative as well.

Mr. JOHNSON. Yeah. That's great. Thank you.

Ms. Blumberg, in your testimony you state you don't believe HSAs will help reduce the number of uninsured; however, in 2006 a survey actually showed that 31 percent of HSA accountholders in the individual insurance market were previously uninsured, and 33 percent of the policies sold to firms in the small group market previously had not offered insurance to their employees. I don't know

anyone in the room believes HSAs will single-handedly solve the uninsured problem, but they obviously are playing a roll in fulfilling the current insurance gap.

Based on those survey results, would you agree?

Ms. BLUMBERG. No, I would not, sir. Part of what we need to recognize is that a significant share of new business in insurance is always coming from employers that had not previously insured; so, the difference between those statistics and what's common for all insurance plans is likely not to be statistically significant. So that's common with all new business in the insurance industry.

We do know that the probability of employer offers and worker take-up among the low income population is falling precipitously. We see the biggest change in health insurance coverage is for the modest-income population. Seventy percent of the uninsured, nonelderly population has incomes below 200 percent of the Federal poverty level. They really have very little ability to purchase health insurance coverage, high deductible plans or otherwise, without significant subsidization.

So, no sir, I don't think that these are mechanisms that are particularly attractive to the low-income population. I appreciate the efforts made by the other witness to assist with his low-income workers; however, that does not necessarily translate to what other employers are doing or are able to do, or what's going on with the vast majority of the uninsured population who have no access to employer-sponsored insurance whatsoever, either through their own employer or through a spouse.

Mr. JOHNSON. Well, my experience with other employers is they're doing the same thing.

So thank you very much. Thank you, Mr. Chairman.

Mr. Becerra, would you like to——

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. I would, Mr. Chairman, and thank you for the second round of opportunities to ask questions. And thank you all for bearing with us. I want to make sure I fully develop this point about the tax deductibility and how we make sure that people are making not just the good use, but the right use of these tax-deducted dollars.

Tell me if—and I probably should direct my questions at Dr. Blumberg and Mr. Dicken since the two of you deal on a monitoring or oversight basis with a lot of these programs and activities. I take out an HSA and a high-deductible health plan.

I continue to pay, put in the maximum amount to my HSA for many, many years. I rarely use my health plan. Before I turn 65, say when I'm 62, I then decide to take advantage of my employer's health plan, and enroll in that health plan. And I stop making contributions into an HSA and no longer have that high-deductible health plan, since I can no longer have it since I have my employer's-based health insurance program.

I have accrued a great amount of money in this HSA that now I don't need to use, because I now have my employer's health insurance to help cover me. Three years later I hit 65, or even while I'm 63, 64, before I turn 65, I get to now make use of that HSA money for non-HSA purposes—can I not?

Mr. DICKEN. At 65, you can use the money. If it's for qualified medical expenses, it's still tax-free. If it's for non-qualified expenses, it would be taxed as income, but perhaps at a lower rate if the individual is now at a lower rate and not subject to the 10 percent penalty that individuals under 65 would have.

Mr. BECERRA. And so I avoid any type of penalty, and all those years that I will have been contributing all that money, which the average American would be taxed on, has not been taxed. And so now when I'm in my later life, 20 years, 30 years after I started putting that money into the HSA only now am I being taxed on that money.

So I have been able to defer tax payments on all those dollars that the average American is ineligible to defer taxes on. So once again, correct me if I'm wrong, but I see the images of a nice tax shelter rising up again.

Mr. DICKEN. If the individual puts in their maximum amount and let accrue an investment income over time, and didn't withdraw it, they could accrue that money for later years.

Mr. BECERRA. Now you may not have these numbers off the top of your head, and I asked my staff to pull these out for me. It, in 2000, I think it's 2008, let's see—in 2004, the maximum amount of money contributed in—or the number—let's see—the percentage of those making a contribution at the maximum dollar amount allowed under the internal revenue for a 401(k) retirement plan, employer retirement plan, rose from, I'm sorry, declined from 6.3 percent of those who have access to 401(k)'s to only 3 percent, slightly over 3 percent of people—strike that, let me read this to you correctly.

In 1996, 3 percent of workers who had access through their employer to a 401(k), or through their employment, to a—for a—through their employment had access to a 401(k) retirement plan, 3 percent of workers who had access put money into that 401(k).

In 2004, the number of American workers who had access to a 401(k) retirement plan, and put money into that plan, rose to 6.3 percent.

So as recently as 2004, 6 percent of Americans who had access to a retirement plan through 401(k) where they could defer their tax payments on money that they invest into a retirement, put money in there. The similar types of numbers are reflected for IRA's, individual retirement accounts, which individuals who don't have access to 401(k)'s can use to help build up a nest egg for retirement.

So very low percentages of Americans who have access to these types of retirement vehicles, or tax-shelter vehicles, use them, and most of them don't max out. And so now we have another vehicle that will be available to tax defer or tax shelter your money, which without the protections and the accountability, leads me to believe that once again what we are doing is creating another shell for folks who already have maxed out on their 401(k), already have maxed out on their IRA—need another vehicle to try to shelter some of their tax dollars that they're earning—can now use the HSA's. Whereas the vast majority of working Americans who never max out on the IRA, never max out on the 401(k) and rarely ever use, if they'll ever use, an HSA are left in the dust. And I'm trying

to figure out where the logic is in trying to now advance on an accelerated basis an HSA plan, which doesn't have the accountability we would want and doesn't target the people who are uninsured, or least insured.

And I hope perhaps, since my time has expired, Mr. Dicken or Dr. Blumberg, you will provide some responses—further elaboration in writing if you think necessary, beyond what you have already provided in testimony—to help at least me understand better why HSAs are a good deal for all Americans, and not just for wealthier Americans.

I thank you Mr. Chairman.

Chairman STARK. Before—I am going to recognize Mr. Camp—but I just wanted to ask Mr. Dicken, if you don't have the numbers handy, well, Mr. Camp is inquiring you to look them up. But I understand that there is information on—how many Federal employees are there? Ten million, I don't know.

Mr. DICKEN. About 8 million are covered in the Federal Employees Health Benefits Program.

Chairman STARK. And where they are in signing up for HSAs I haven't polled the Committee because I didn't want to raise that issue, but I suspect we wouldn't be much different. But we have current information on that, as to their income levels and their age levels, do we not?

Mr. DICKEN. Part of the work that we've done is to look at the Federal employees health program and——

Chairman STARK. We'll come back.

Mr. DICKEN. Okay.

Chairman STARK. Mr. Camp?

Mr. CAMP. Well, I do want to just complete your answer on the non-qualified withdrawals. If there are senior citizens, they still have to pay taxes on that withdrawal. And there wouldn't be a penalty as there would be a penalty and taxes if you're under 65, but there still would be taxes paid.

Mr. BECERRA. Mr. Camp, would you build on that?

Mr. CAMP. Well, if I have time at the end. I mean, this is—I do want to understand a little bit more. I think the characterization I just heard isn't really accurate. But you know, what I'd like to understand is some of the other things that these plans, these high-deductible health plans, HDHP's, can offer and particularly the Alegent efforts in the whole area of price transparency.

I mean, one of the problems we have in health care is that people don't know the cost, they don't have any investment in the cost. And one of the things we are trying to get at is certainly making more options available to consumers of health care. And in order to have options available, you have to have some price transparency. Can you kind of describe to me some of the efforts that Alegent has gone to in that regard?

Mr. SENSOR. Absolutely. The construct that we shared earlier was that for this to work in aggregate, you really have to have great benefit plans, you really need to offer alternative access points. But also to have an engaged consumer, you need to treat them as a consumer, and that means give them relevant quality and cost information.

Specifically answering your question, we have a web-based cost tool that I'm happy to report is patent-pending, although we are sharing it readily with any other interested party. It literally validates what specific insurance plan you have and because it's bouncing off a third party insurance database, it also can determine not only just what plan you have, and therefore what benefits, but it also can estimate your out-of-pocket expense based on your co-pays and deductibles. It's a searchable database of some 500 existing procedures and tests.

And of course, hit the print button at the end, because this is based on your self-assessment most often, and you might not have the right procedure at all. But it begins to engage them in the relevance of cost.

Mr. CAMP. I mean, that is truly an innovative approach. And you know, I do want to—first of all, I appreciate all of our witnesses coming, even though I may not necessarily agree with everything I have heard from all of our witnesses.

I do want to say though, I think Mr. Sensor, the fact that you—and actually have thousands of employees that you are providing an alternative for is something real world that none of the other witnesses have contributed today. And I very much appreciate your coming forward and doing that, being the only person with your point of view in this panel of five. I wish we could have had more with that point of view, I think we would have had frankly, a better debate.

Again, I think we're getting part of the information. I am not afraid of a full and open debate on this subject. Frankly, I think that's something that would be helpful to this Committee.

But I very much appreciate the fact that you've come forward and shared the experience that you have had at Alegent in a real world, with real employees who have real health care needs. And you are providing not only the wellness portion of this in a way, and incentivizing that as you have described in your testimony, but also the price transparency side, so that people can actually make a better choice.

We are not just at the whim of the provider in terms of what costs and what procedures we may engage in. So I thank you for coming forward. And again, I have some time, so I would be happy to yield to the gentleman.

Mr. BECERRA. I appreciate that, Mr. Camp. My point isn't that they don't pay taxes on the money that they subsequently use for non-health-related purposes, it's that for years they've been able to defer the accrual of those monies and the interest that's been gained and not pay taxes, at least not at the rates that they would have paid while they were working.

If you are now 65, and retired, your income probably has dropped dramatically, and you are paying taxes on income based on your retirement income, not your income that you earned while you were working. So all those years of amassing these dollars in these accounts can now be used at a far less expensive rate, tax-wise, for people who could afford money into these HSAs.

Whereas, I think the average American would not have that opportunity to do so—that's my point here.

Mr. CAMP. Yeah. And that may be a theoretical point, that—but we don't have current data in terms of what is happening now. In fact, we had testimony that not enough people are putting cash in their accounts. So I don't know that's you know a solution without a problem maybe——

Mr. BECERRA. I could tell you——

Mr. CAMP [continuing]. But I tell you that——

Mr. BECERRA. I tell you that's the theory that Wall Street would love to bank on, and could probably sell lots of policies on.

Mr. CAMP. I think over time, if people have saved for their health care needs, I don't consider that the negative that you do——

Mr. BECERRA. Oh, I——

Mr. CAMP [continuing]. Because they are then responsible for their health care. And if they don't have coverage in a particular area, that comes out of pocket.

Mr. BECERRA. I concur with you on that point.

Mr. CAMP. So you know, I don't know that I see the real negative within accumulation of an asset. Now one of the things is that it is also transferable, and that is an important part of this as well, to give an incentive to then provide for your own care.

That also is, as we have a broader debate on Medicare and the inadequacies of that program and the unsustainability of that program, I think having more seniors with a health care nest egg is a good thing.

Mr. BECERRA. I agree.

Mr. CAMP. So that's just a different point of view. But I understand the point you are making. And yes, they may have an income tax rated at a slightly lower rate, but they are responsible for their health care. Thank you.

Mr. BECERRA. Mr. Chairman, we really have an opportunity to indulge in this type of conversation and questioning of the witnesses, and I am not sure if the chairman is going to gavel the hearing to an end. But to the degree that we still have an opportunity with the experts that are sitting here to continue the conversation, I'd love to do so.

I mean, usually I'm in a rush as well, but this is one of those occasions where if I had some lunch I could share with you I would. Could we continue this colloquy and——

Chairman STARK. Sure. I just want, I want to get in on this, just because I'm, it's interesting. I want to get back. I am going to come back to have Mr. Dicken tell us about what the, what happens to 8 million Federal employees. But I have felt for some time—and I guess I have some credentials—I taught up marketing up the river for you, in the—School a thousand years—before you were born probably.

But nonetheless—and I also sold used cars once after I flunked out of MIT for a brief period. So I understand about peddling things to people they don't need, and some of the questions. And I had some trouble, Mr. Sensor, in—for example, I just don't think that we can purchase medical care the way we could purchase a flat-screen TV.

I can't go to Consumer Reports. I could maybe go to U.S. News & World Report and look up hospitals that are in your group, and

see where you rank in various procedures. But if I don't—well, if—isn't my son, and like his daddy I don't travel to Omaha on business—you don't know what I'm talking about, do you? You never read—and the animals?

Okay. Well, read—and the anteater, that's—or the—at any rate—but if we go online to you and my costs for example—and I've come to Omaha and I decide I've been, I haven't had my colonoscopy, all I can get from you is that my responsibility, this is for self-pay, is somewhere between $1,761.60, and $2,826.40.

Now that's a pretty big spread, isn't it. And worse—one of my staff brought this one up—I can't pronounce it, but she just had it, and she is now negotiating with her orthopod, so this may be helpful. If you want to have a cruciate ligament repair, you would suggest that it's between $16,338.40 and $23,850.40.

Hardly—and a cardiac catheter is between 12,000 and 16,000. But the problem is you get in to have it, and you don't know whether you are going to have to spend the night in the hospital and have—I mean, I guess what I'm saying is that unless these are amounts that as the economists would say, are below your indifference level.

You know, if you are really thinking about—you are making 45, 50 grand a year, and you look at this 12- to 16,000, that's pretty—and you only got in your account, I've only got 10. Okay. So I am looking at two, to six out of pocket. It, it isn't very helpful.

And that's—I would love to see what your outcomes are on these procedures, 5 years or 10 years later, if we had that kind of—which we don't have. But just to load me up with my limited knowledge with these numbers, which are large, doesn't seem to be very helpful in how I'm going to save any money doing it. How does—that's—how does that help us?

Mr. SENSOR. Chairman Stark, I appreciate the question, and I'm flattered that staff took a look at our Web site.

Chairman STARK. Well, they were confused by it, I'll tell you that. And in Medicare, you can't get any information, so—go ahead.

Mr. SENSOR. You know, the intention of My Cost is to open the conversation with consumers about what the darn thing costs.

And the reality is the industry has not readily come forward with cost estimates, because it is a complicated question. How many days in the stay, what peripherals are, what tests are going to be ordered, et cetera, et cetera, et cetera?

Another construct that I might just throw out there for consideration is the individual who has just been encouraged to get an MRI, and they're told by their physician that MRI is optional, that they could wait 3 days and see what the results are.

There would be no downside of doing so. And you know, they might want to find out how much that MRI is going to cost.

They might want to take a look at their monthly statement, which they are provided through our health plan, and determine whether that's the right use of their funds. So I would submit to you that although those complex procedures that were cited have a wide variance in cost, that's by definition and nature there's a lot of unknowns until you and your doctor decide your course of cure.

But on outpatient and other costs, it's more precise.

Chairman STARK. Some of my colleagues here in Washington argue that disclosing prices will actually increase them, because it'll undermine incentives to provide deep discounts.

Now, has releasing your prices affected your competitive position in your market?

Mr. SENSOR. I don't believe that sharing our prices has changed our competitive position, nor was it intended to.

Chairman STARK. Okay.

Mr. SENSOR. I think my competitors are now asked as to what their prices are on a more regular basis.

Chairman STARK. Would you agree for example, in the—however purchasing outpatient prescription drugs, particularly under part D, where transparent data could actually affect behavior, and could lead to lower overall spending.

Would you agree that prescription drug costs should be transparent?

Mr. SENSOR. Absolutely.

Chairman STARK. Right on. Thank you. Mr. Dicken, could you enlighten us as to what the 8 million bureaucrats and elected officials have done with regard to health savings accounts.

Mr. DICKEN. Certainly, I can give information on that. As you indicate, there are about 8 million people enrolled, both Federal employees, retirees, and their dependents, in the Federal Employees Health Benefits Program.

This year, out of more than 200 different plan options, over 30 have health savings account, or other CDHP option available.

The enrollment in those—we can certainly give for the record the actual number—but it's in the few hundred thousands of the 8 million that are enrolled in the HSAs.

Chairman STARK. Let me, let me translate. You are saying less than 500,000 out of the 8 million are in these?

Mr. DICKEN. Yes, I believe that's right. And we can get the actual enrollment if that's helpful. In 2006, we were able to look at some of the HSAs offered through FEHBP, and also looked at the premiums, looked at the enrollment, looked at the income of Federal employees. And we were able, in contrast to our IRS data, to compare people that were insured through HSAs with those that were insured through other health plans in FEHBP.

And we consistently found that Federal employees had higher Federal incomes in the HSA plans than in the other FEHBP options.

Chairman STARK. And you're going to quantify some of that and submit it to use, both for my information and the record, could you?

Mr. DICKEN. I certainly can.

Chairman STARK. Okay. How about age?

Mr. DICKEN. When we've looked at age in the Federal employees program, we looked at age across a number of different programs and have found different stories. Within the Federal employees health program, people enrolling in the health savings accounts were I believe somewhat younger than all Federal employees in other plans.

But when we took out retirees, much of that was because these new HSAs were not covering retirees. So the difference was much

less when we did not look at the retirees covered through the FEHBP.

Chairman STARK. All right. Would you stipulate that Federal employees are the best guardhouse lawyers on the face of the Earth, and that they play these benefits like a 6-dollar harp? And for example, if they plan a pregnancy, they know which plan has better maternity benefits.

And with our plan, we can switch, really without penalty every year, so that you can plan your medical necessity and get the best plan at the best price at that time.

And that generally isn't available I think, to other employees in this country.

Mr. DICKEN. Certainly one of the signature characteristics of the Federal employees health program is the choice of plans, with an annual open enrollment period.

Chairman STARK. I want to thank all of you. Sure you can. Mr. Becerra?

Mr. BECERRA. Thank you. And I'll try to be brief, because I know we have stretched this out. Actually, first to Mr. Camp's point. I think it would be wonderful if we found a way to help working Americans save up money, build up a nest egg, not just for the retirement, but for their health care cost, because as we have heard, the greatest portion of those health care costs come at the end stage of life.

And so I think that's something that we should all work forward, work toward on a bipartisan basis. My difficulty is that my parents wouldn't get the benefit from this plan that we are discussing right now, because their income would have been way too low to ever be able to deposit money into a health savings account, and to be able to afford a high-deductible health plan.

And so they would have been left out. Fortunately, my father, who worked as a laborer for most of his life, got health insurance through his union. And so we were covered. So with one occasion, when my mother almost died as a result of hemorrhaging, we were covered.

But I know that this plan wouldn't be available to my parents were they not covered through their union health plan. And that's a concern, providing assistance to those who can afford to get health care, period, and really leaving out those who are most in need of trying to either keep what they've got or find it, the tens of millions of Americans.

And Mr. Dicken, I want to go back to a point. I asked my staff to pull up some numbers, because I was concerned again about the oddity of these HSAs and what might happen if we don't do a good job of trying to monitor them, since they don't have the type of oversight that other types of tax-deferred programs have.

The numbers I get back are that there are about 140 million tax filers in America, people who file their taxes on an annual basis. That's the number for 2007, probably a little bit more for this year, 2008, but we'll see. The audit rate in 2007 was 1 percent, a little over a million tax filers had their filings audited, 1 percent.

And here we have a program that has less oversight than does Medicare. Medicare requires providers to provide documentation for reimbursement. We have other plans, flexible spending accounts

require documentation in order to be able to take advantage of the tax advantages in the FSA's.

But here we have almost nothing, except voluntary action on the part of those who have these HSAs to submit documentation. Now let me ask this, say I have back problems, or I say I have back problems. I go to a chiropractor once, and I have documentation that I have back problems.

I could then go and get massage services for the rest of my life and submit that as documentation of a health care, that I received massage services from whatever place that does massaging that I want to go to. And there's a good chance that would qualify if I one, was among the 1 percent who ever got audited by the IRS, and whether or not I used those HSA tax-deferred dollars the right way; is that correct?

Mr. DICKEN. It's a very small share that are audited, a very small share of tax filers are filing it, and the qualified medical expenses as defined by IRS are fairly comprehensive in what's included.

Mr. BECERRA. So if I went in and got massage services that could qualify as a health expense.

Mr. DICKEN. I don't know the specific tax rules on that provision, but there are a wide range of medical expenses that can qualify.

Mr. CAMP. Would the gentleman yield briefly?

Mr. BECERRA. Certainly.

Mr. CAMP. Just to say that—I know we are focusing on HSAs, but charitable contributions I think, for the purpose of the record, don't require any up-front receipts. And those contributions dwarf anything HSAs account for—245 billion in charitable contributions are not substantiated, or require any up-front receipt as well.

Mr. BECERRA. I think Mr. Camp raises another good point. There are some $32 billion that we as Americans forgo in tax receipts as a result of the $295 billion that are contributed to charitable organizations. That is $32 billion that we could use to pay health care for seniors under Medicare, or for modest-income families to have help, get access to health care.

And we again trust that Americans actually made a contribution to a charitable organization, because again we don't monitor this, do the oversight necessary. It would be very difficult, given the number of Americans who do make charitable contributions. We take on good faith, that people aren't ripping off the government.

And to some degree, there's no way we would have police, IRS police go into every home and asking "please prove to us that you actually gave this money to a charitable organization." That is precisely my point. And so we know for a fact that there are people, I think the exact, more accurate number is $340 billion in uncollected tax revenues on an annual basis.

So we know a lot of folks are taking advantage of every type of tax shelter, including charitable deductions, to not pay their fair share of taxes, which means all those other Americans who are paying taxes end up having to pay more to make up for those who are getting off the hook.

And so my concern with HSAs is not that we shouldn't provide this to people so they have access to health care. Absolutely, if we

could figure out a way to do this. But I'm not interested in having folks who already have access, because their wealth allows them to have access to health insurance, who probably are healthier than most, and therefore unlikely to have to use health care services.

And then get to cheat the government out of paying their taxes the way most working Americans do, simply so we can claim that we are trying to increase the number of people who will have health care. And in some cases, perhaps it works well. But I'm not interested in having it work well in some cases. When someone in my district pays taxes, or in any of your districts pays taxes, they expect us to make the best use of the money.

And if we don't do our job of oversight to make sure that this is a good program that is working well for all Americans, then we are not doing our job. And I just think at this stage, HSAs are not a proven commodity. They haven't proven how they work. We can't document that they work well.

And at this time when we have these massive budget deficits, it seems to me that to not do more oversight, not put more requirements for oddity, simply is telling the American people we are not interested in taking care of the tax money they have entrusted to us to spend well. So with that I yield back Mr. Chairman.

And one more thing, I apologize that I confused the numbers on IRA's and 401(k)'s, and I'll submit for the record the document that gives the numbers. So that way it's not, it doesn't seem so muddled in the record.

I yield back.

[The information follows:]

Contributions to and Earnings in 401(k)-Type Plans

The percentage of workers ages 21–64 participating in a 401(k)-type plan increased from 23.3 percent in 1996 to 30.2 percent in 2004 (Figure 4). At the same time, the mean (average) contribution for those making a contribution increased from about $3,600 to just over $4,000 in 2004 dollars.[3] The percentage of those making a contribution at the maximum dollar amount allowed under Internal Revenue Service (IRS) regulations also rose, from 3.2 percent in 1996 to 6.3 percent in 2004.[4] Furthermore, the average annual earnings in 401(k)-type plans increased from $4,985 in 1996 to $5,711 in 2004.

The mean contributions and the percentage making the maximum contribution increased with age and educational attainment. For example, in 2004, the mean contribution of workers age 21–24 was $1,605, compared with $4,862 for those ages 55–64. Married and male workers had higher mean contributions and likelihood of making the maximum contribution than those in the other marital status categories or females. The male mean contribution was $4,700, whereas the female mean contribution was $3,420.

Among workers with family income of $10,000 or above, the mean contribution and likelihood of making the maximum contribution increased with family income. The mean annual contribution of workers with $10,000–$19,999 of family income was $1,338. This mean contribution level rose until reaching $5,511 for those with family incomes of $75,000 or more.[5] For those with less than $10,000 in family income, the numbers are not comparable, as this group contains those with uneven monthly incomes, so the annualized monthly income used in this study distorts the results for this group.[6]

Average earnings in 401(k)-type plans increased with age and family income ($10,000 and above) and were higher for those workers who were married, white, or male. Those workers with the lowest educational attainment had the lowest average earnings, while those with the highest educational attainment had the highest average earnings of any subgroup. However, for those with educational attainments in between, the average earnings were very similar to those with the highest education.[7]

Deductible Contributions to and Earnings in IRAs

The proportion of workers ages 21–64 making a tax-deductible IRA contribution in 2004 was 6.3 percent, up from 5.0 percent in 1996 (Figure 5).[8] Of those making a contribution, the mean contribution in 2004 was $2,218.[9] This compares with $1,972 (2004 $s) in 1996. However, the percentage of those making the maximum allowed contribution declined from 66.4 percent in 1996 to 38.0 percent in 2004. Consequently, when the contribution limits were raised in 2002, the average contribution increased, but approximately half of the percentage who previously made the maximum contribution did after the limit increased. Average annual earnings in IRAs were down to just over $3,000 in 2004 from almost $4,500 in 2001.

The mean contribution increased with workers' age and educational attainment. Family income had no clear impact on the mean contribution, which showed a relatively small difference across income groups and did not trend in one direction or the other. White workers and workers in the "other" race/ethnicity category had higher mean contributions, while male workers also had a slightly higher mean contribution than females. Males were more likely to make the maximum contribution, as were those ages 55–64 or having a graduate degree.

Workers ages 55–64 had the highest average annual earnings within their IRA, at $4,923. Those workers with at least a college degree had higher average annual earnings than those with less educational attainment (approximately $3,200, compared with $2,700–$2,800). Males had significantly higher average earnings at $3,518, whereas the females' average earnings were below $2,400. Family income did not correlate with average earnings in any specific fashion, just as with contributions, showing that income is not the only indicator of individuals' decisions to save or accumulate funds in an IRA.

Private-Sector Defined Contribution Plans, Participants, and Assets

The previous section showed a significant increase in the percentage of workers participating in 401(k)-type plans; the latest Department of Labor Form 5500 publication reveals the analogous increase of 401(k)-type plans in the private sector.[10] The number of 401(k)-type plans in the private sector increased from 29,869 in 1985 to 418,553 in 2004 (Figure 6). While the overall number of defined contribution plans (of which 401(k)-type plans are a subset) has also grown substantially, it has leveled off in recent years. In 1975, the number of DC plans was 207,748; by 2000, it had reached 686,878, before declining to 635,567 in 2004.

Chairman STARK. I want to thank the witnesses for their intelligence and their patience. It's been very informative. I wanted to not only take up Mr. Chernew's offer to read, to get his journal, if I can get that past the Ethics Committee, and for any of the rest of you. Mr. Sensor, your information that would otherwise be public on your plans, would be appreciated.

Any of the rest of you, you have gathered what the tenor of our interest is today from the Members' questions. If you want to send it to me, I will certainly reproduce it and distribute it to all Members of the Subcommittee. Much of this information will be helpful to us, and it will change, and we'll appreciate your input.

Thank you all very much, and the hearing is adjourned.

[Whereupon, at 12:39 p.m., the Subcommittee was adjourned.]

[Submissions for the record follow:]

Statement of America's Health Insurance Plans (AHIP)

I. INTRODUCTION

America's Health Insurance Plans (AHIP) is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. The innovative products offered by our members include high-deductible health plans (HDHPs) that are compatible with Health Savings Accounts (HSAs).

We appreciate this opportunity to comment on HSAs and their role in providing more Americans with access to high quality, affordable health care coverage. This innovative approach to health care financing is helping a substantial number of previously uninsured consumers purchase coverage, receive preventive health care services, accumulate savings for their future medical needs, and take a more active role in making decisions about their health care.

Our statement focuses on three broad topics:

- The current state of the HSA marketplace, including the findings of a census we conducted in January 2008 and other data showing the value HSA products offer to consumers;
- Legislative issues, including opportunities for further improving HSAs and our concerns about pending legislation that would impose duplicative requirements on individuals and families who have HSAs; and
- The importance of promoting transparency in health care prices and quality to help HSA accountholders and other consumers make informed health care decisions.

II. AN OVERVIEW OF THE HSA MARKET

To learn more about consumers' experiences with HSAs, AHIP has conducted a comprehensive census of the HSA market several times over the past 5 years. The most recent census,[1] conducted in January 2008, was based on responses from 97 health insurance companies, including 66 companies that offer HSA/HDHP plans in the individual market, 88 companies offering plans in the small group market, and 89 companies offering plans in the large group market.

We found that HSA-compatible HDHPs covered more than 6.1 million Americans in January 2008, a 35 percent increase since last year. This increase was strongest in the small employer group market. Previous AHIP censuses found that 4.5 million were enrolled in January 2007, 3.2 million in January 2006, and 1.0 million in March 2005. This growth represents a strong start for a relatively new health care option that was unknown to most Americans just a few years ago.

A closer look at AHIP's January 2008 census data reveals a number of significant findings:

- Thirty percent of individuals covered by HSA plans were in the small group market, 45 percent were in the large group market, and the remaining 25 percent were in the individual market.

[1] AHIP, *January 2008 Census Shows 6.1 Million People Covered by HSA/High-Deductible Health Plans*, April 2008.

- HSA products accounted for 31 percent of new coverage issued in the small group market and, additionally, for 27 percent of newly purchased policies in the individual health insurance market.
- In 2007, the average balance in HSA accounts was approximately $1,380 and the average amount spent from HSA accounts was $1,080. Throughout 2007, 83 percent of HSA accounts had an average balance of $2,500 or less. These findings are based on responses from 30 health insurance companies that had information on the HSA accounts established by their policyholders.
- The average premium for an HSA plan, for single coverage, was $1,519 for persons age 20–29, $2,278 for persons age 30–54, and $3,724 for persons age 55–64. For family coverage, the average premium was $3,825 for persons age 20–29, $5,125 for persons age 30–54, and $7,170 for persons age 55–64.
- Forty-six percent of all HSA plan enrollees in the individual market—including dependents covered under family plans—were age 40 or older. Another 29 percent were age 20–39, and the remaining 25 percent were age 19 or younger.
- HSA plan enrollment as a percentage of individuals with private coverage is estimated to be the highest in Minnesota (9.2 percent), Louisiana (9.0 percent), the District of Columbia (8.7 percent), Vermont (7.5 percent), and Colorado (7.1 percent). The new AHIP census includes data for all 50 States.

Access to Preventive Care

Other research findings by AHIP demonstrate that access to preventive care on "day one" is a central component of the HSA approach to health care coverage. Last year, AHIP released a survey[2] showing that recommended preventive care is covered on a first-dollar basis by most HSA/HDHP products. This survey was based on responses from 36 companies that covered more than 1.7 million HSA/HDHP enrollees as of July 2007. Overall, this survey shows that 84 percent of HSA plans purchased in the group and individual markets provide first-dollar coverage for preventive care. Virtually all HSA plans purchased in the large group market (99 percent) and small group market (96 percent) provide first-dollar coverage for preventive care. Additionally, 59 percent of policies purchased in the individual market cover preventive care on a first-dollar basis.

First-dollar coverage for preventive benefits is potentially less frequent in the individual market because premiums for individual coverage do not receive the same favorable tax treatment as premiums for employer-based coverage. As a result, consumers who purchase HSA/HDHP coverage in the individual market have an incentive to pay for preventive benefits through their tax-free HSA rather than through higher premiums. AHIP supports full tax deductibility for all health insurance premiums to create a level playing field for consumers who purchase health insurance coverage on their own without an employer sponsor.

Other survey findings show that among HSA/HDHP policies offering first-dollar coverage for preventive care, 100 percent cover adult and child immunizations, well-baby and well-child care, mammography, Pap tests, and annual physical exams. Nearly 90 percent provide first-dollar coverage for prostate cancer screenings and more than 80 percent offer first-dollar coverage for colonoscopies. The types of preventive screenings covered by HSA/HDHP policies include newborn screenings such as PKU tests; adult blood pressure and cholesterol tests; children's vision tests; height, weight, and body mass index measurements; bone mineral density testing for women; colorectal cancer screening; prostate cancer screening for men age 50 or older; and adult screening for depression and substance abuse.

Plan-Specific Research Findings

Additional research findings have demonstrated that HSAs are having a favorable impact on patient health and helping consumers to make cost-effective decisions.

A 2-year study by Cigna HealthCare,[3] focusing on more than 110,000 persons with either HSAs or Health Reimbursement Arrangements (HRAs), found that persons with these plans were receiving 14 percent more preventive care visits by the second year, when compared to those with traditional coverage. This study also found that pharmacy costs for new HSA and HRA enrollees were 6 percent lower than for persons with traditional coverage, due to the use of lower cost options such as generic medications and mail order purchasing.

The Cigna study also found that first-year medical costs were more than 12 percent lower for persons with HSAs or HRAs—and 5 percent lower in the second year—when compared to those with HMO and PPO plans. These savings were achieved while HSA/HRA enrollees continued to receive recommended care at the

[2] AHIP, *A Survey of Preventive Benefits in Health Savings Account (HSA) Plans*, July 2007.
[3] *CIGNA Choice Fund Experience Study*, October 2007.

same or higher levels as when they were enrolled in traditional plans the prior year. This evaluation was based on more than 300 evidence-based measures of health care quality. Taken together, these findings clearly indicate that the cost savings resulted from consumer involvement in health care decisionmaking—*not* because consumers were foregoing needed medical care.

Another study,[4] by HealthPartners, found that the cost of care for enrollees in HSAs and HRAs was 4.4 percent lower, after adjusting for illness burden, than for those with traditional coverage. These savings did not negatively impact patient care, as the study also concluded that the utilization of preventive services and medication for chronic conditions was comparable for members in consumer-driven health plans and traditional plans. The probable explanation for lower costs is that HSA/HRA plan enrollees were 13 percent more likely to use HealthPartners' web-based tools that compare costs and quality. One such tool lists facilities that offer the most cost-effective service for 38 medical procedures, while another tool provides consumer information based on 87 measures of clinical quality and patient service.

Additional research[5] by UnitedHealth Group shows that its Definity Health plan members who have HRAs receive preventive care and evidence-based care at rates equivalent to or better than a benchmark population of other consumers. This 2007 study found that Definity Health plan members were 16 percent more likely than the benchmark population to receive both cervical cancer screening and prostate cancer screening. Other findings indicate that Definity Health plan members with diabetes, asthma, coronary artery disease, and congestive heart failure received care to treat or monitor their conditions at rates that were equivalent to, and for some measures higher than, the benchmark population.

United's Definity plan achieved these improvements while at the same time bringing costs under control. A more recent United study,[6] published in April 2008, shows that overall health care costs for Definity's members were 10–12 percent lower than for PPO members in 2004–2006 after being very similar in 2003. This study further concluded that persons with chronic conditions also were benefiting from slower growth in costs "while utilization was not sacrificed." This study addressed a 4-year period (2003–2006) and covered more than 370,000 enrollees in the final year.

HSAs Have Broad-Based Appeal

As indicated by AHIP's January 2008 census, HSA plans are being purchased at comparable rates by persons who are young, middle-aged, and near-elderly. The diversity of consumer interest in this product also is evidenced by the fact that although the small group market currently is experiencing the most rapid growth in HSA plan enrollment, a significant share of overall HSA plan enrollment also can be found in both the individual market and the large group market.

Other research findings suggest that the broad-based appeal of HSAs also applies to Americans of different income categories. A report by eHealthInsurance indicates that 45 percent of HSA plan enrollees had annual incomes of $50,000 or less in 2005. Another report,[7] issued by the Government Accountability Office (GAO) in April 2008, indicates that 41 percent of HSA tax filers for 2005 had annual incomes below $60,000.

The GAO also reported that tax filers who reported HSA activity in 2005 had higher incomes on average than other tax filers. This finding has been used by some critics to suggest that HSAs are benefiting only higher income persons or that HSAs are being used as tax shelters for the wealthy. These assertions fail to recognize several key facts:

- The GAO analysis would have been more meaningful if it had compared all HSA plan enrollees to consumers who purchased other private health insurance coverage. Instead, the GAO comparison focused on one category of HSA plan enrollees (i.e., those who reported contributions to or distributions from an HSA) and compared them to all other tax filers, including those who are uninsured or covered by public programs.
- The GAO analysis omitted two key categories of HSA plan enrollees: (1) those who did not make contributions to or distributions from their accounts in tax year 2005; and (2) those who purchased a HDHP, but waited until the following tax year to open an HSA. To the extent that these groups include lower- and

[4] HealthPartners, *Consumer Directed Health Plans Analysis*, October 2007.
[5] Uniprise, *Quality of Care, Executive Summary*, April 2007.
[6] Uniprise, *The Effect of Consumer-Driven Health Plans (CDHPs) on Healthcare Costs and Utilization*, April 2008.
[7] GAO, *Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes*, April 2008.

middle-income individuals and families, the GAO's estimate is likely to overstate the number of higher-income consumers who have established HSAs.
- As noted by AHIP's most recent census, the average HSA account balance for 2007 was approximately $1,380 and the average amount spent from HSAs in 2007 was about $1,080. These data indicate that individuals are funding their accounts for current health care costs and not using them to "shelter" large amounts of income from Federal and State income taxes.
- The Kaiser Family Foundation/HRET 2007 study[8] on employer health benefits indicates that, among employers that help to fund HSAs, the average employer contribution is $806 for single coverage and $1,294 for family coverage. These contributions are a valid approach to meeting the health care needs of employees and do not constitute any kind of tax "shelter."

III. LEGISLATIVE ISSUES

AHIP and our members have serious concerns about pending legislation that would impose burdensome requirements on HSA accountholders. We also want to take this opportunity to offer our recommendations for future legislation to strengthen and improve HSAs.

Substantiation Requirements for HSAs

On April 15, the House approved legislation, H.R. 5719, that would require HSA accountholders, beginning in 2011, to follow substantiation requirements similar to those that currently apply to Flexible Spending Arrangements (FSAs). In addition, this bill would authorize the Treasury Secretary to require annual reporting by HSA trustees of amounts paid from HSAs that are not substantiated along with the names, addresses, and tax identification numbers for the account beneficiary. We strongly oppose these proposed requirements because they duplicate existing HSA requirements and would increase the cost of these accounts for consumers and employers. We urge Committee Members to carefully consider the following concerns.

First, it is important to recognize that accountholders already must report all HSA activity to the Internal Revenue Service (IRS) and pay taxes and penalties on non-qualified expenditures. Every year, HSA accountholders are required to file Form 8889 with the IRS and report contributions to and expenditures from the account. If money in the HSA is used for a non-health care expense, the accountholder must pay taxes on the amount and an additional 10 percent penalty (the penalty is waived if the accountholder is age 65 or older, is disabled, or is deceased). The IRS can audit the accountholder if it believes the HSA is not being used properly.

Another important consideration is that FSAs and HSAs are fundamentally different kinds of accounts and should not be treated the same. Employers determine how money in an FSA is spent and the employer is responsible for administering the account and reporting to the IRS. If the FSA is used for "non-qualified" health care expenses, the entire account can be disqualified. In contrast, an HSA belongs to the accountholder who can keep the money if he or she changes jobs or switches to a new insurance plan. The accountholder is responsible for reporting on the account and may use HSA funds for non-health care expenses as long as he or she pays taxes and the penalty.

In addition, FSA-style substantiation requirements would lead to higher costs and increased paperwork for consumers. The majority of HSA transactions are electronic while many FSA transactions are paper, since the consumer must prove to the account administrator that they used the money for a health care transaction (e.g., a prescription drug purchased at a grocery store pharmacy). The FSA administrator must process and approve any expenses. Accordingly, FSA transactions cost more than similar transactions from an HSA. The increased costs and paperwork requirements of imposing FSA-style substantiation on HSAs likely will be passed on to the accountholder.

We also are concerned that substantiation requirements will require consumers to give personal health information to the banks that administer these accounts to determine if money spent from the account was used for a qualified health care expense. As a result, accountholders would be required to give the bank information on the prescriptions and over-the-counter drugs they purchase, the doctors they use, and the health care services they receive.

Finally, requiring substantiation of HSAs will reduce consumer and employer interest in these innovative new accounts. HSAs give consumers the ability to save tax-free money to pay for health care expenses and to make better health care decisions. HSAs also allow some individuals and small employers to purchase insurance

[8] Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits, 2007 Annual Survey*.

for the first time. Requiring substantiation will increase the administrative costs borne by small businesses who maintain accounts for their employees. Adding cost and complexity to the accounts will have a chilling effect on enrollment and cause some employers to drop HSAs as an option for their employees.

Legislative Recommendations

While HSAs are proving to be highly effective in helping many consumers meet their health care needs, there are a number of additional steps Congress could take. AHIP is recommending the following proposals to address the unique needs and circumstances of the chronically ill, early retirees, and many others for whom HSAs can be a valuable coverage option.

- *Allow Increased HSA Contributions for Individuals With Chronic Disease:* Congress should allow employers to assist employees or their family members who suffer from chronic conditions by permitting increased contributions into the HSAs of individuals who are enrolled in disease management or care coordination programs.
- *Allow Health Plans to Include Coverage for Prescription Drugs for Chronic Conditions:* High-deductible health plans should be allowed to cover certain prescription drugs used to treat chronic conditions without the patient first being required to satisfy the minimum annual deductible on the HDHP. This proposal will help patients with acute illness or injuries access prescription drugs and assure that they do not forego their medications due to cost concerns.
- *Allow Early Retirees to Save for Retiree Health Coverage:* Early retirees—those in the 55–64 age category—should be allowed to use HSA funds to purchase retiree health coverage. This proposal would make transitional coverage more affordable for individuals who sometimes struggle with the high cost of health insurance in the years just before they become eligible for Medicare.
- *Allow Spouses to Have an HSA Even if Their Spouse Has an FSA:* Individuals should be allowed to establish an HSA if their spouse has an FSA. Individuals currently are disqualified from setting up an HSA if they have a spouse with an FSA. This rule unfairly limits consumer choice, particularly in instances where the individual's medical expenses are not being covered with funds from the spouse's FSA.
- *Allowing Separate Deductibles for Individual Family Members:* HDHPs for family HSAs should be allowed to include separate deductibles, also known as "embedded deductibles," for individual family members below the family deductible set by the statute—but at least as high as the individual deductible set by the statute. Allowing lower embedded deductibles for each family member will make it easier for families with HSAs to meet their health care expenses.
- *Allow HSA Funds to Be Used to Purchase Medigap Coverage:* Seniors should be allowed to use HSA funds to purchase Medigap coverage. Current law, which prohibits this use of HSA funds, fails to recognize the high value offered by Medigap policies and the fact that millions of Medicare beneficiaries are well-served by supplementing their basic Medicare benefits with Medigap coverage.
- *Allow Employers to Coordinate HRAs and FSAs:* Employers should be allowed to combine HSAs with FSAs or HRAs to cover medical expenses below the HDHP's deductible. Currently, employers face regulatory barriers that significantly limit their ability to combine these products.
- *Contribution Limits:* The HSA contribution limits should be increased to allow consumers to contribute an amount equal to the out-of-pocket limits of their HDHP. Increasing this threshold will enable HSA accountholders to meet their health care expenses with after-tax dollars.
- *Give Consumers More Time to Establish an HSA:* The current HSA law punishes consumers who may wait to set up their HSAs by prohibiting the use of HSA funds for any medical costs incurred before the account was set up. Experience has shown that some individuals may wait several months to complete the paperwork needed to establish an account at a financial institution—thereby delaying when they can use HSA funds to pay for medical costs. Consumers should have until the end of the tax year (April 15) to set up the account in order to pay for health costs incurred during that year.
- *End the Penalty on Veterans:* Veterans who use VA health care facilities should be allowed to contribute money to an HSA. Under current law, any veteran who has accessed the Veterans Administration medical system within the past 3 months is prohibited from putting money into an HSA. This restriction hurts veterans—especially returning service personnel who have service-related injuries.

IV. IMPORTANCE OF TRANSPARENCY FOR HSA ACCOUNTHOLDERS

Because HSAs provide an opportunity for consumers to be more actively engaged in their personal health care decisions, greater transparency—with respect to both the price and quality of health care services—is critically important in helping consumers and other purchasers make informed, value-based decisions. HSA accountholders are a catalyst for transparency and our efforts are evolving to meet their needs. AHIP and our members are strongly committed to making price and quality information more widely available and more easily understood for consumers with all types of health coverage.

In November 2006, AHIP's Board of Directors endorsed a set of principles that serve as the cornerstones for our involvement in transparency initiatives:

- **Supporting a uniform approach for the disclosure of relevant, useful, actionable and understandable information to facilitate consumer decisionmaking and choice.** Information should be made available to enrollees to permit accurate comparisons of physicians, hospitals and other practitioners. Additionally, information should be disclosed and displayed in a format that is easily accessible and understandable; consumers should be educated on how to use the information as appropriate.
- **Supporting efforts that advance transparency while preserving competition and basing analyses on objective, agreed-upon measures.** Consumers and purchasers need accurate information to make more informed health care decisions. At the same time, the disclosure of this information should comport with antitrust guidelines to ensure that vigorous competition continues to thrive in the marketplace. To achieve this objective, ranges—such as the 25th percentile and 75th percentile of payments to hospitals which are disclosed by Medicare—should be the model for disclosing price information.
- **Recognizing the importance of linking quality and cost of care.** Disclosure of information about the quality of care which physicians and hospitals provide and costs of services is important to enable consumers and purchasers to evaluate their health care options, and to enable practitioners to learn how their practices compare to their colleagues' practices in terms of effectiveness and efficiency. At the same time, consumers need assistance in interpreting this information and using these data to make informed decisions.
- **Developing the tools to analyze high-utilization, high-cost services or conditions where variation exists.** The nation needs to build the capacity to analyze certain agreed-upon episodes of care as well as certain services or procedures. Presenting data on episodes of care (e.g., pregnancy)—rather than merely on services (e.g., labor and delivery)—will allow consumers to make more comprehensive and informed assessments. The episodes of care selected should align with conditions which address areas where practice variation exists, have high utilization rates and are known to be cost drivers.
- **Supporting the disclosure of information for physician as well as hospital services.** To promote continuity of care and prevent the proliferation of silos within the health care system, stakeholders should advocate for the disclosure of physician performance information as well as the disclosure of hospital performance information. Disclosure of information for other providers—such as nursing homes and home health agencies—also should be considered.

One area where AHIP's transparency principles can be seen in action is through our involvement in the AQA Alliance. AHIP and several prominent physician leaders began a vitally important collaboration 4 years ago with physician groups and other key stakeholders to establish the AQA Alliance.[9] This coalition, which includes private groups like the American Academy of Family Physicians and the American College of Physicians, as well as the Federal Agency for Healthcare Research and Quality (AHRQ), has as its goal the development of uniform processes for performance measurement and reporting—a fundamental building block needed for consumer health information systems. Its processes would: (1) allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered; and (2) enable practitioners to determine how their performance compares with their peers in similar specialties. This effort now encompasses more than 135 organizations, including consumer groups, physician groups, hospitals, accrediting organizations, private sector employers and business coalitions, health insurance plans and government representatives.

To date, the AQA has approved 218 *quality* clinical performance measures in 32 different ambulatory care setting areas, many of which are being incorporated into

[9] For more information about the AQA Alliance, *see http://www.aqaalliance.org/*.

health plan provider contracts. These measures represent an important step in establishing a broad range of quality measurement. The AQA has also approved a prioritized list of conditions for which *cost of care measures* should be developed, and the group continues to make further progress towards that goal.

In addition to its work in the area of performance measurement, the AQA has implemented a pilot program in six sites across the country, with support from the Centers for Medicare & Medicaid Services (CMS) and AHRQ. These pilots, now known as the Better Quality Information or BQI sites, combine public and private sector quality data on physician performance. This program is testing various approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing consumers with meaningful information they can use to make choices about which physicians best meet their needs. Ultimately, we anticipate that the results of this pilot program will inform a *national framework* for measurement and public reporting of physician performance, which is an important step toward advancing transparency and providing reliable information for consumer decisionmaking.

On another front, many AHIP member plans have individually implemented their own initiatives to empower their members by supplying them with price as well as quality information designed to support consumer decisionmaking. While they use a variety of approaches, these plan initiatives—often in the form of easy-to-use tools that allow consumers to access secure websites—encompass providing such resources as the following:

- **Access to price data on specific physicians:** Members of many health insurance plans can type in a particular physician's name, specialty, or office address and view a menu of common procedures, and determine the cost of procedures, such as routine office visits or x-rays.
- **Access to quality data on physicians:** Members of some health insurance plans can access information on either plan-specific or regional collaboratives' websites regarding clinical quality delivered by a specific physician, including indicators based on adverse events, clinical processes, use of health information technology such as electronic medical records, as well as overall efficiency in the use of medical services.
- **Access to hospital price and quality information:** Members in many plans may have access to cost ranges for common procedures at hospitals and surgery centers, in some instances separating out doctor fees from facility costs, as well as tools to ascertain the comparable value of those facilities.

Several of AHIP's members also are participating in regional quality collaboratives that are aggregating data across a given market. These data aggregation efforts combine data from multiple health plans in a region to give consumers a more comprehensive picture of a physician's quality across his/her population. Still other AHIP members are experimenting with pilot projects allowing consumers to rank the cost and quality for dozens and sometimes hundreds of common medical procedures. All of these pioneering efforts are designed to help Americans make value-based health care decisions.

V. CONCLUSION

AHIP appreciates this opportunity to discuss the value of HSAs and opportunities for further strengthening this important health care option. We appreciate the support many Committee Members have demonstrated for HSAs and we look forward to continuing to work with you to advance solutions for further expanding access to high quality, affordable health care.

Statement of American Benefits Council

The American Benefits Council (the "Council") appreciates the opportunity to submit this written statement to the Subcommittee regarding the increasing utilization and effectiveness of health savings accounts ("HSAs") and high deductible health plans ("HDHPs"). The Council is a national trade association representing principally Fortune 500 companies and other organizations that either sponsor or administer health and retirement benefit plans covering more than 100 million Americans.

HSAs are a fairly new health coverage option for American families, having been established by Congress in 2003 as part of the Medicare Modernization Act. Nevertheless, for millions of Americans, HSAs have already become an important tool in securing essential health coverage for themselves and their families. Early data

from the Government Accounting Office ("GAO") and other third parties is encouraging, indicating that HSAs are working as intended for the vast majority of Americans who use them. HSA/HDHP arrangements can provide vital "first-dollar" medical coverage for accountholders (and their spouses and qualifying dependents), while utilizing important cost-sharing principles to help lower health coverage costs generally for individuals and employers alike. It is critical that we allow this important new health care option to fully develop and that we permit comprehensive data to be collected on the role it can play in providing quality health care at an affordable price. Any actions to apply new restrictions or burdens on this option would be premature and would risk eliminating a health care tool already being successfully used by millions of Americans.

The following is a summary of our comments:

- Health savings accounts have become an increasingly important tool for millions of Americans in securing lower cost, high quality medical coverage. Recent data compiled by GAO indicates that an estimated 6.1 million Americans were covered by HSA/HDHP arrangements as of January 2008.
- Early data and testimony before the Subcommittee on May 14, 2008, indicate that the vast majority of HSAs include comprehensive "first-dollar" preventive care coverage and that HSAs can succeed in reducing health care costs for American families, while also resulting in increased wellness and quality of care.
- Recent data strongly indicates that participants have sufficient HSA assets to meet actual out-of-pocket expenses under HDHPs, and (i) HSA withdrawals are being used principally for current-year qualified medical expenses, and (ii) HSAs, rather than being used primarily by high-income individuals as a tax shelter, are being used by individuals at a broad range of income levels. For example, one survey found that 45% of all HSA enrollees in 2005 had annual incomes of $50,000 or less, and there are good reasons to believe that this percentage may be even higher today.
- Current rules regarding HSA substantiation are consistent with the treatment afforded other special purpose accounts and health tax provisions. As discussed below, there are *numerous* instances under the Internal Revenue Code ("Code") where amounts withdrawn from a special purpose account are *not* subject to mandatory third party FSA-like substantiation rules. Similarly, the general approach toward health expenditures under Federal tax law does *not* require third party substantiation for an individual to obtain a specific income tax deduction or other tax-favored treatment.
- Imposing third-party substantiation requirements on HSAs is not appropriate, will increase costs for HSA accountholders and limit options for health coverage at a time when such options should be expanded. The Council urges Members of the Subcommittee, and Members of Congress more generally, to oppose the imposition of third-party substantiation requirements on HSAs, such as the requirements included in H.R. 5719 (the "Taxpayer Assistance and Simplification Act of 2008").

HSAs Are An Increasingly Important Component To Many American Families' Health Coverage

Recent data compiled by GAO indicates that the number of Americans covered by HSA-eligible plans increased from 438,000 in September 2004 to an estimated 6.1 million in January 2008.[1] This represents a 1,400% increase in their use in just over 3 years. Moreover, a recent study by America's Health Insurance Plans ("AHIP") found that HSA-usage increased by 35% in the 12-month period from January 2007 to January 2008.[2] American families and workers are indisputably turning to HSAs in increasing numbers to help control their ever-rising health coverage costs.

Early data also indicates that the increased use of HSAs is broad-based. Specifically, recent survey data by AHIP indicates that of those individuals covered by HSAs, 30% were in the small group market, 45% in the large group market, and 25% in the individual market.[3] In addition, it is very significant that the greatest

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[1] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of John E. Dicken, Director of Health Care, Government Accountability Office).

[2] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of America's Health Insurance Plans) (hereinafter ("AHIP").

[3] *See* AHIP, *supra*.

growth in the HSA/HDHP market is in the small plan market, where health care coverage has been a constant public policy challenge.[4]

HSAs Can Reduce Health Costs And Improve Quality Of Care

In this era of ever-rising health care costs—costs that continue to well outpace general inflation as measured by the Consumer Price Index ("CPI")—American workers and their employers continue to look for ways to help rein in these costs without negatively affecting health standards and quality of care. As Michael Chernew, Professor of Health Care Policy for Harvard Medical School, testified, cost sharing can reduce excess utilization and health expenditures generally, and HSA/HDHP coverage utilizes certain cost-sharing principles like upfront deductibles and copayments to help reduce excess utilization.[5]

Testimony from Wayne Sensor, CEO of Alegent Health, also provides a first-hand example of how HSA/HDHP coverage can both reduce costs *and* lead to increased health standards and quality of care. Specifically, Mr. Sensor testified that "there is a significantly higher level of engagement among those participants [in one of our HSA plans]." He stated that HSA participants "consume more preventive care than any other plan we offer," and that "[m]ore than 45% of HSA participants completed their health risk assessments, compared to just 16% in our PPO plan." On top of all of this, he noted that "[f]rom 2006 to 2007, the cost trend in our two HSA plans declined a full 15%!" [6]

Mr. Sensor's testimony is supported by findings from another study performed by HealthPartners. This study found that the cost of care for participants in HSAs and health reimbursement arrangements ("HRAs") was 4.4% lower than for those individuals with traditional low-deductible coverage.[7] The study also found that the cost savings did not impair the standard of care and that the utilization of preventive care services and medication for chronic illness was equivalent to that of individuals covered under more traditional low-deductible plans.

Data Indicates HSA/HDHP Coverage Utilizes Important "First Dollar" Preventive Care Coverage

As Mr. Sensor's first-hand experience at Alegent Health demonstrates, HSA/HDHP coverage, if structured correctly, can achieve its intended result—providing quality care to Americans and their families at reduced costs. One component of successful HSA/HDHP coverage appears to be the inclusion of "first-dollar" preventive care coverage. A survey by AHIP last year showed that recommended preventive care is covered on a "first-dollar" basis by the vast majority of HSA/HDHP products.[8] Overall, the survey found that 84% of HSA/HDHP plans purchased in the group and individual markets provide "first-dollar" coverage for preventive care. Specifically, nearly all HSA plans purchased in the large group market (99%) and small group market (96%) provide "first-dollar" coverage, while 59% of HSA/HDHP policies sold on the individual market include such coverage.[9]

The AHIP survey also found that among those HSA/HDHP policies offering "first-dollar" coverage for preventive care, 100% provide coverage for adult and child immunizations, well-baby and well-child care, mammography, Pap tests, and annual physical exams. Nearly 90% of the policies provide "first-dollar" coverage for prostate screenings and more than 80% offer "first-dollar" coverage for colonoscopies.[10]

Early Data Strongly Indicates That Participants Have Sufficient HSA Assets To Meet Actual Out-Of-Pocket Expenses Under HDHPs

AHIP's most recent census data indicates that HSA enrollees had an average account balance for 2007 of approximately $1,380 and withdrew on average $1,080 to reimburse qualified medical expenses, including those expenses not otherwise covered under their HDHP.[11] Additionally, early findings indicate that many employers

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[4] *See* Id.

[5] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of Michael E. Chernew, Ph.D., Professor of Health Care Policy, Harvard Medical School).

[6] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of Wayne Sensor, CEO, Alegent Health).

[7] *Consumer Directed Health Plans Analysis*, HealthPartners, October 2007.

[8] *See* AHIP, *supra*.

[9] *See* Id.

[10] *Id.*

[11] *See* Id. *See also Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes*, GAO–08–474R (April 2008), at 8 (stating that in 2005,

Continued

are contributing substantial amounts to their employees' HSAs. Specifically, GAO reports that of those small and large employers that made contributions to HSAs in 2007, the average annual contribution totaled $806.[12]

The Council views these early findings as very encouraging. One criticism of HSAs has been that accountholders cannot contribute a sufficient amount to an HSA on an annual basis to meet their actual out-of-pocket expenses. This is due in large part to the fact that the maximum HSA contribution limit is almost certainly significantly less than the plan's maximum out-of-pocket limit (for example, for 2008, the maximum HSA contribution limit was $2,800 for self-only coverage and $5,900 for family coverage, but the maximum out-of-pocket limit for HDHPs was $5,600 and $11,200, respectively). Notwithstanding this fact, the data indicates that American families have been able to utilize their HSAs to effectively meet their out-of-pocket liability under the HDHP. This is very welcome news as it suggests that HSA/HDHPs meet both the cost and coverage needs of the average American family.

Data Indicates That HSAs Are *Not* Being Used As Tax Shelters By High-Income Individuals

The early data from GAO and AHIP is also encouraging for another reason. Contrary to concerns by some that HSAs would be used primarily by high-income individuals as an IRA-like retirement savings vehicle, the data indicates that HSAs are being used by both lower- and higher-income individuals principally to meet current year health costs.

With respect to the specific income levels of those individuals who are currently utilizing HSAs, available data for the 2005 tax year indicates that nearly 50% of all HSA enrollees had annual incomes of less than $60,000. Specifically, the recent GAO report indicates that 41% of HSA tax filers for 2005 had annual incomes below $60,000.[13] Similarly, a survey by eHealthInsurance, an online broker of health insurance policies, found that 45% of all HSA enrollees in 2005 had annual incomes of $50,000 or less.[14] The same survey found that 41% of HSA purchasers were not covered by health insurance during the preceding 6 months.[15]

Notably, the findings for the 2005 tax year may fail to accurately reflect current trends in HSA usage and may, in fact, understate the percentage of low- and middle-income HSA enrollees. This is because, as part of the Medicare Modernization Act, Congress allowed participants in early HSA-like accounts, called Medical Savings Accounts ("MSAs"), to convert these accounts into HSAs. Because MSAs generally were only available to self-employed individuals and small business owners—persons who on average would likely have higher incomes than the average American worker—the data for 2005 may well underestimate the number of low- and middle-income individuals who are currently enrolled in HSA/HDHP coverage.

Recent data from AHIP indicates that for 2007, HSA enrollees withdrew on average 80% of their annual contributions to reimburse current-year qualified medical expenses. Moreover, the GAO report states that "average contributions and average withdrawals generally increased with both income and age."[16] Thus, although higher-income individuals on average contributed more to their HSAs in a given year, they also withdrew more contributions during the same year. These early findings, when taken together, are very encouraging because they indicate that that HSAs are *not* being used primarily by higher-income individuals as a retirement savings vehicle or tax-shelter, but rather are being used by both lower- and higher-income individuals to obtain essential current-year health care coverage.

Lastly, some have pointed to the early data indicating that all HSA account balances are not "spent down" on an annual basis (as is frequently the case with FSAs given the "use-it-or-lose-it" rule) as evidence that HSAs are being used inappropriately as a tax savings vehicle. Such critiques fail to recognize the mechanics of HSA/HDHP coverage in light of the statutory contribution limits and potential out-of-pocket expenses. As noted above, in the vast majority of instances, the HSA participant's potential out-of-pocket exposure under the related HDHP can be as much as 200% of the maximum HSA annual contribution. Thus, to the extent that accountholders do not withdraw all of their HSA contributions in the same year (*i.e.*, as

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the average HSA contribution was $2,100, with the average withdrawal being approximately $1,000).

[12] *See* Id at 9 (*citing* Kaiser Family Foundation and Health Research and Educational trust, *Employer Health Benefits: 2007 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.:2007). It should also be noted that in a study conducted by Mercer during the same period which covered only large employers, the average contribution was $626. *Id*. at 9.

[13] *Id*. at 6.

[14] *See* AHIP, *supra* (citing eHealthInsurance survey findings).

[15] *See* Id.

[16] *See* GAO, *supra*, at 8.

necessary to meet health expenditures), this should be viewed as positive from a public policy perspective. This is because any remaining account balance at year-end will help ensure that accountholders have sufficient HSA assets to meet potential out-of-pocket expenses under the HDHP plan in later years.

Available Data Indicates That HSA Monies Are Being Used For Qualified Medical Expenses

The early data, as compiled by GAO, suggests that amounts withdrawn from HSAs are being used by accountholders for qualified medical expenses. The GAO report states that "[o]f the HSA funds that were withdrawn in 2005, about 93 percent were claimed for qualified medical expenses."[17] Moreover, recent statements by a Treasury Department representative before the Ways and Means Committee, indicate that 8.4% of all HSA accountholders list at least some of their HSA distributions as nonqualified taxable distributions.[18]

Under current rules, amounts withdrawn from HSAs that are not used for qualified medical expenses are subject to substantial negative tax consequences. Specifically, such amounts are subject to income tax at the accountholder's marginal tax rate as well as an additional 10% penalty tax. To the extent that an accountholder fails to accurately report taxable withdrawals, he or she would likely also be subject to various accuracy-related penalties and additions for the underpayment of income tax, as well as related interest.

The early data indicates that accountholders are using their HSAs as intended—primarily to reimburse qualified medical expenses not otherwise covered under the HDHP. Moreover, where amounts are withdrawn and are not used to reimburse qualified medical expenses, the data indicates that accountholders are correctly reporting such amounts as subject to income taxation under the current rules.

Current Rules Regarding HSA Substantiation Are Consistent With Other Special Purpose Accounts And Health Tax Provisions

Some persons have suggested that the treatment of HSAs under Federal tax law—specifically the lack of a third-party substantiation requirement—is unparalleled and otherwise unique to HSAs. Such assertions are not correct. There are *numerous* instances under the Code where amounts withdrawn from a special purpose account are *not* subject to mandatory third party FSA-like substantiation rules, such as with respect to withdrawals from 529 college savings plans or withdrawals from IRAs in connection with a qualifying first-time home purchase

Under current rules, participants in 529 college savings plans are not required to obtain third party substantiation prior to withdrawing amounts from the 529 plan. However, as with HSAs, the accountholder must report in connection with his or her annual income tax return, the amount of withdrawals that were for qualified educational expenses and, as such, are eligible for tax-free reimbursement. Moreover, as with HSAs, to the extent that withdrawn amounts are not attributable to qualified expenses, such amounts are subject to income and penalty tax.

This is also the case with respect to withdrawals from IRAs in connection with a qualifying first-time home purchase. Under current Federal tax rules, IRA owners generally may not make a withdrawal from their IRAs prior to attaining age 59½ without otherwise being subject to a 10% penalty for early withdrawals. If, however, the withdrawal is made in connection with the purchase of a qualifying first home, the 10% penalty does not apply. As with HSAs, there is no requirement that the provider or administrator of the IRA first substantiate that the IRA owner has satisfied the requirements necessary to avoid the 10% penalty. Rather, all withdrawn amounts are generally coded by the provider or administrator on the annual information return as being subject to the 10% penalty. When the IRA owner then files his or her annual tax return, he or she then certifies on the return the amount of annual withdrawals that was used for purposes of purchasing a qualifying first home. Thus, no third party substantiation is required.

With respect to the treatment of medical expenses more generally under Federal tax law, it is HRAs and FSAs—rather than HSAs—that are in fact the exception to the rule. This is because, as with HSAs, the general approach towards health expenditures under Federal tax law does not require that a taxpayer obtain third party substantiation of qualifying medical expenses in order to obtain a specific income tax deduction or other tax-favored treatment.

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[17] *See* Id at 9.

[18] *April 9, 2008 Mark-up of H.R. 5719 by the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (comment by Thomas Reeder, Benefits Tax Council, Dept. of Treasury) (as reported by Congressional Quarterly).

One example of this can be found under Code section 162(l), which allows self-employed persons to take an above-the-line deduction for qualified medical care. In order to avail oneself of the deduction under this provision, the self-employed individual must certify on his or her annual income tax return the amount that he or she paid for qualified health insurance during the respective tax year. As with HSAs, no third party substantiation is required under Federal tax law, although the taxpayer remains subject to accuracy-related penalties and additions under Federal tax law.

Another example is section 213(a) of the Code, which permits a taxpayer to deduct qualifying medical expenses in excess of 7.5% of their adjusted gross income. As with HSAs, taxpayers are *not* required to obtain third party substantiation of such expenses under Federal tax law. Taxpayers merely certify on their annual tax return the amount of qualified medical expenses that they incurred that make them otherwise eligible for the deduction. Taxpayers do, however, remain subject to accuracy-related penalties and additions under Federal tax law.

Code section 72(t) is another example of the more general rule under Federal tax law under which taxpayers are not required to obtain third party substantiation in order to obtain favorable tax treatment. As noted above, in very limited circumstances, pursuant to Code section 72(t), taxpayers are excepted from the 10% penalty tax for early distributions from a qualified retirement plan, including an IRA or employer-sponsored retirement plan. In addition to withdrawals for purposes of a qualifying first-time home purchase, Code section 72(t) also excepts from the penalty withdrawals attributable to certain incurred qualified medical expenses. As with HSAs, Code section 72(t) does not impose third party substantiation requirements. Taxpayers do, however, remain subject to accuracy-related penalties and additions to the extent of mischaracterized or ineligible withdrawals.

Imposing Third-party Substantiation Requirements on HSAs Will Increase Costs and Limit Americans' Options for Health Care Coverage

In light of the foregoing, the Council urges Members of the Subcommittee, and Members of Congress more generally, to oppose the imposition of third-party substantiation requirements on HSAs, such as the requirements included in H.R. 5719 (the "Taxpayer Assistance and Simplification Act of 2008"). The available data indicates that the current regime is working and that substantiation rules like those required with respect to flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs") are not needed at the present time.

At a time when Americans continue to struggle to afford their health care coverage and/or secure appropriate coverage, imposing third party substantiation rules would impose additional costs and burdens on HSA providers and accountholders. These additional costs could operate to limit the attractiveness and efficacy of HSAs.

Americans' options for health coverage need to be expanded at this time, not limited, and imposing third party substantiation could negatively affect the use and/or effectiveness of HSAs. Moreover, given the relative newness of HSAs generally and the encouraging early data indicating that such substantiation is unnecessary, the Council opposes the imposition of third party substantiation rules in connection with HSAs.

Conclusion

HSAs were never intended to be a comprehensive answer to all of America's health care problems. Rather, HSAs were designed to be one important option for Americans families seeking lower-cost but high-quality comprehensive coverage. As the GAO report makes clear, for a significant percentage of American families, HSAs have become an integral part of their health coverage and, thus, should not be curtailed at this time.

More than ever before, Americans need good health coverage options. For a significant segment of American families, HSA/HDHP coverage meets this need by providing lower-cost, high quality coverage. Moreover, as noted above, early data is encouraging and suggests that for the vast majority of HSA participants, HSA/HDHP coverage is operating as intended by Congress. But early data is just that—"early." It is critical, therefore, that we allow this new health care option to develop without additional burdens or restrictions. The Council believes that there is no justification for changes that could curtail the use and/or effectiveness of HSAs. Otherwise, we risk taking away from millions of American families a vital tool in securing affordable, quality health care coverage.

Statement of Consumers for Health Care Choices at the Heartland Institute

Chairman Stark, Mr. Camp, and Members of the Committee,

I would like to set the record straight on some of what you have been told about Consumer Driven Health Care generally, and Health Savings Accounts specifically.

These programs are not a panacea for our health care problems, but neither are they intended to be. There are no simple solutions to the problems in health care and we would be foolish to think there should be. H.L. Mencken was famously quoted as saying, "For every complex problem, there is a solution that is simple, neat, and wrong." There is hardly a problem more complex than health care, so solutions will be equally complex.

But HSAs and Consumer Driven Health Care (CDHC) are significant steps in the right direction. They are beginning to address some of the most intractable problems in the system. In particular—

1. Patient behavior is changing—people are being more cautious about needless use of services.
2. Consumers are more compliant with treatment regimens, especially those with chronic conditions.
3. The rate of increase in health care costs is down substantially for people and groups in these plans.
4. The demand for information, transparent prices, and patient support services is high.
5. The adoption rate in the benefits market is sizzling.
6. The transformation of service delivery is beginning, though still very formative. Early indicators include the growth of retail clinics, concierge medicine practices, and medical tourism.

These changes are not mere speculation. They are taking place among real people in real life, and have been verified by actual results reported on by employers, consulting firms, and health plans.

Most of what you have been told in the testimony to date is either mistaken, based on suppositions or surveys of uninformed people, or simply irrelevant to CDHC. For example—

- You were told that lower-income people cannot afford the out-of-pocket responsibility that comes with an HSA. You were not told how those same people could afford the higher premiums that are required to avoid that cost. In fact, money that is paid to an insurance company for first-dollar coverage is money that is lost forever. Lowering the premium and using that saving to pay directly for services gives the low-income consumer a chance to save money that would otherwise be lost.
- You were told that the tax break associated with HSAs is unprecedented and a boon to the "wealthy." In fact, the tax treatment of HSAs is precisely the same tax treatment afforded to employer-sponsored health insurance. Premiums are untaxed and benefits are untaxed. It is true that the "wealthy" get a larger tax benefit than the unwealthy, but that is the case for employer-sponsored comprehensive coverage as well as for HSAs. Further, the opportunity to save, say, $2,000 a year that would otherwise go to an insurance company is of far greater benefit to the low-income worker who earns $20,000 a year than to the wealthy executive who makes $200,000, regardless of the tax treatment.
- You were told that "the sick" do not benefit from HSAs because of the higher out-of-pocket responsibility. In fact, both the healthy and the sick have less out-of-pocket exposure with an HSA, a point that was well documented in a recent Health Affairs article. In fact, HSAs *limit* a patient's out-of-pocket exposure, something that is not true for the Medicare program, for instance.
- You were told that most health care spending takes place above the deductible associated with an HSA, so they will not have "a significant effect on overall spending." This is probably true, but irrelevant. HSAs are having a profound effect on lower-cost routine spending and that is significant by itself. Other strategies are needed for high-cost services with or without an HSA.
- You were told that many people with a high-deductible health plan do not open up an HSA. That, too, is true but irrelevant. The HSA itself is attractive for those people who are able to get a tax benefit from passing their direct payments through the account. Other people, especially those who pay no income taxes, may find it more suitable to simply pay cash at the time of services or to keep their funds in some other, non-HSA, account. Further, there is likely to be a lag time between the point of enrollment and opening up that account. This is not a problem.

- You were told that some people who have to pay directly for care or for prescription drugs may fail to do so to save the money. That also may sometimes be true. But there is never any guarantee that people will always fill their prescriptions and take their medications regardless of the financing scheme. In fact, we know that many health conditions are caused or aggravated by patient behavior under all health insurance systems. But, to the extent that people with CDHC are more knowledgeable and more invested in their own care, their compliance will be better than it is for other benefit programs. And that is precisely what we are seeing in the market.

In fact, with one exception your witnesses were people with long-standing hostility to HSAs and consumer empowerment in health care. The one exception could speak only to the experience of his own company and his own employees. But his positive experience is being replicated by tens of thousands of similar cases throughout America today.

There is a revolution underway in American health care. It is being transformed from a system that is inconvenient, unaccountable, uncompetitive, bureaucratic, of questionable quality, and far too expensive into one that is efficient, convenient, accountable, innovative, and matches quality and costs in a way to deliver the best value to the American consumer. This is an enormous undertaking, and HSAs are only one element of this movement.

I urge the Members of the Health Subcommittee to open your eyes and your minds to the dramatic changes that are taking place right now, right in front of you.

Thank you for your attention.

Greg Scandlen
greg@chcchoices.org

Statement of Consumers Union

Summary

Recent experience with health savings accounts and high deductible health insurance policies has confirmed what economists and policy analysts have predicted for the past decade: In a voluntary health insurance marketplace where lawmakers have let the free market write the rules, encouraging high deductible policies combined with tax favored savings accounts, benefits the rich and increases the financial burden on the sick. **It is time for Congress to call a halt to this misguided policy and turn its attention to health system reform that will provide guaranteed coverage to all Americans, while improving the quality of care in the system and constraining costs.**

Concerns about High Deductible Health Insurance and Health Savings Accounts

Variation of risk in health insurance markets. The health insurance market is different from the market for other consumer goods. When a car manufacturer sells a car, the seller has no reason to care who is buying it: age, sex, health status, income simply do not matter. Health insurance is a different kind of market. Not only do sellers care very much about the nature of the buyer, if allowed they create detailed underwriting rules that discriminate against buyers by design—denying coverage to the sick, excluding any pre-existing conditions (for which the need for care and coverage is greatest), and charging higher premiums to the older and sicker.

The key economic factor that makes health insurance markets different from markets for other consumer goods and services is the tremendous variation in risk of the population. A small percent of the population (regardless of whether you consider the young or the old, the rich or the poor, males or females) tends to account for a large part of health care expenditures. Most people are healthy and incur very small if any costs. Consumers take their own health risk profile into account when deciding about what type of policy (and deductible) they should seek. Insurers take consumers' health risk profile into account when deciding whether to provide coverage.

Data from the Medical Expenditure Panel Survey (MEPS) (with adjustments by the Lewin microsimulation model) reveals the extent of variation that exists. While these numbers are from 2000, there is no doubt that the variation continues to exist. While average health care costs (of those with employer based coverage) was $2,628 in 2000, those with spending in the lowest fifth incurred just $30 of health

care expenditures. Those in the top tenth of spending incurred costs of $16,710.[1] This variation of risk goes to the heart of the need to find a way to spread costs broadly in order to keep costs affordable to those at the highest risk level.

Erosion of "Choice" of Low-Deductible Coverage. Employer-based coverage and government financed programs such as Medicare spread the risks and costs across broad populations. Because of the variation of risks, and different selections made by people of different health status, high deductible plans can not exist in the long-term in a marketplace that offers low-deductible plans as well. Ultimately, low-deductible plans will be driven out of the market, with "premium spirals" driving out comprehensive coverage. **This is the hidden secret that the supporters of high deductible tax breaks tend to leave off of their talking points: Instead of increased choice in the marketplace of health insurance options, over time, the "choice" of high deductible coverage is likely to crowd out low deductible choices.[2]** It is particularly troubling that this basic change in the health insurance marketplace could take place without explicit debate and consideration of the full long-term implications and elimination of true choice.

When consumers are given a choice between high and low deductible coverage, a small percent will elect the high deductible option. People with high incomes and low health care costs are most likely to be attracted to the high deductible/HSA option (and relatively low premium). It is ironic that the choice that most consumers want may well not be available to them as the market plays out over several years.

Benefit to the Healthy and the Wealthy from Tax Encouragement of High-Deductible Health Insurance. Tax policy now encourages high deductible health insurance policies by making contributions to health savings accounts tax deductible. This tax policy, combined with high deductible health coverage, has been predicted to appeal disproportionately to the healthy and the wealthy.

- The healthy benefit because they have the new prospect of a tax-sheltered investment in which money is not taxed when put in or when withdrawn (i.e., not needed by the healthy to cover health care costs).
- The wealthy, with higher tax brackets, benefit disproportionately because the tax savings are larger at higher tax brackets than lower tax brackets.

A recent study by the Government Accounting Office[3] found that people with Health Savings Accounts (HSAs) in 2005 had an average adjusted gross income of $139,000 compared with $57,000 for other filers. This is an alarmingly high differential and should be a wake-up call to policymakers for the validation that it provides to the concerns that opponents (such as Consumers Union) of this policy have expressed over the last decade. In addition, a study conducted at the University of Minnesota found that the average income of employees who enrolled in high deductible coverage was 48 percent higher than the income of employees who did not.[4]

A study conducted of 4,680 Humana employees found that enrollees in high-deductible policies were "significantly healthier on every dimension measured."[5]

Distraction from the Issue of the Uninsured and Underinsured. The potential for health savings accounts and encouragement of high deductible insurance to split the healthy from the sick and the rich from the poor is alarming. But of even greater concern is the distraction they pose to turning the full attention of policymakers and the health policy community toward the challenge of providing true health care security to all. **We should be moving full-steam toward the goal of guaranteed, quality, affordable health care for all consumers, not spending countless resources creating and analyzing new models that promise to split the healthy from the sick, shift costs to the sick, and expand the inequities in our system.**

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[1] Gail Shearer, Consumers Union, *The Health Care Divide: Unfair Financial Burdens*, August 10, 2002, Table 10.

[2] Daniel Zabinski, Thomas M. Selden, John F. Moeller, Jessica S. Banthin, Center for Cost and Financing Studies, Agency for Health Care Policy and Research, "Medical Savings Accounts: Microsimulation Results from a Model with Adverse Selection, *Journal of Health Economics* 18 (1999) (195–218).

[3] "Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes," Letter of April 1, 2008 from Jon E. Dicken, GAO, to Chairman Waxman and Chairman Stark, Government Accountability Office.

[4] Jon B. Christianson, et. al., "Consumer Experiences in a Consumer-Driven Health Plan," *Health Services Research*, 39:4, Part II (August 2004).

[5] For an expanded discussion of the Humana and University of Minnesota studies, see Gail Shearer, "Commentary—Defined Contribution Health Plans: Attracting the Healthy and Well-Off," *Health Services Research*, 39:4, Part II (August 2004).

Statement of Energy Manufacturing Company, Inc.

To Whom It May Concern:

Energy Manufacturing is a mid-sized designer and manufacturer of hydraulic cylinders located in Monticello, IA. We supply outside equipment manufacturers (OEMs) throughout the world. We compete with other manufacturers located in the United States, Europe, China, Canada and South America. Our competition ranges from OEMs themselves to small manufacturers to multinational corporations.

We rely very heavily on a highly skilled workforce in order to compete. Consequently, personnel costs, including medical costs is one of our most critical issues. Like many Midwestern manufacturers, we have experienced significant increases in the cost of insuring our employees. We offer medical benefits that, to our knowledge, surpass most companies similar to us in eastern Iowa. We believe this provides an advantage for us in attracting and retaining talented workers in an increasingly competitive labor market.

On January 1, 2008 we instituted a medical plan supported by HSAs for our salaried workforce. We made this change after a careful analysis of the issue. We attended seminars on how to reduce medical costs and consulted extensively with our insurance agency. Our agents provided considerable research to aid our decision.

Rep. Stark's analysis of HSAs could not be more wrong as it relates to the situation at Energy Manufacturing. The first thing we learned in our research is that cost shifting will not be effective in reducing hyperinflationary increases in medical costs. The monthly premiums that our employees contribute pale in comparison to the costs resulting from chronic medical conditions such as diabetes, heart disease and obesity. Our research indicated that companies that have been successful in reducing the rate of medical inflation used a combination of wellness programs, disease management and consumer education to encourage a healthier workforce and identify medical risks before they become major medical expenses. In doing this, a medical benefits program benefits the employee and reduces the cost for all participants in the program.

Our program does not discourage participants from seeking needed medical care. First, all of our wellness benefits including annual physicals, mammograms, pap smears, colonoscopies and childhood immunizations are covered 100% by our medical plan without deductibles or co-pays. Second, the company contributes a significant amount of money to each employee's HSA. When we combined reduced premiums to the employee and employer contributions, we found that the cost of the increased deductible was neutralized. Third, we conducted health risk assessments (HRA) for all employees. The HRA results in a confidential report that identifies each participant's (and their families if they choose to participate) health risks. The HRA was 100% paid by the company and will be performed, and company paid for, on an annual basis.

Our HSA plan has not saved us any money in medical premiums or in the cost of administering our program. Our HSA plan is a long-term investment that we believe will result in a healthier, more educated workforce. Already, our employees have become more educated on the cost of medical procedures and prescription drugs. They are more likely to shop around for drugs and are more likely to get a second opinion before undergoing expensive medical procedures. This behavior benefits our employees and introduces incentives for cost containment by medical providers and prescription drug retailers. Our employees do this because they have now invested in a savings account (HSA) that grows with each day. They are committed to becoming healthier and in building a nest egg that can be used if major medical expenses become a necessity.

What Energy has done is no secret. The research is readily available for companies who want to invest in a program like ours. Some companies may believe that HSAs can be used as a cost shift mechanism rather than an incentive. However, we suspect that these companies will be very disappointed in the results. We believe that more companies will follow the strategy that Energy has employed as they realize that the only way to control medical costs is to encourage healthy and consumer savvy behavior.

The bill that is being discussed is not about accountability or preventing fraud. It is an attack on a medical benefits model that has tremendous potential to benefit all parties. This is evident in the generalizations and false assumptions included in the May 7 advisory.

We urge you to support the HSA structure as it is currently written. These plans will result in a healthier workforce. They will force cost control and accountability onto medical providers. Finally, they will provide a means for employees to save money for their own medical care.

Thank you for your consideration of this extremely important matter.

Sincerely,

ENERGY MFG CO., INC.

Michael Szymaszek
President

Patrick T. Kopf
Chief Financial Officer

Gregg Eiles
Vice President Operations

Kenneth Rosenbecker
Vice President Sales

Cc: Sen. Richard Grassley
Sen. Tom Harkin
Rep. Bruce Braley

Statement of Henderson Brothers, Inc.

Comments regarding House Ways and Means Committee hearing on HSAs & CDHP

In the late 1970's when, prior to managed care, when most U.S. citizens had employer sponsored health insurance, the typical plan was one that contained an up-front deductible and usually 80% co-insurance. The average family paid 40% of their medical bills and people were generally happy with what coverage they had.

Managed care (promoted by the Federal Government) brought to the table a new approach that represented a pre-payment of medical care. What it did to the economic makeup of a private insurance risk was, in retrospect, catastrophic to our health care environment. Managed care's biggest influence at this point is to create an abnormal demand for services driving supply and creating double-digit insurance price increases for employers trying to do right by their employees. Today's family share of the health care bill is around 11%. The end result is embodied in the fact that the most widely prescribed pharmaceutical is a statin—so people can continue to live unhealthy lifestyles as long as they take the pills to keep their cholesterol under control. Insurance is a basic concept of risk sharing. If you apply the concept of today's typical health insurance model to auto insurance, you would have a policy that has a $20.00 copay for collision, and when your tires, brakes and windshield wipers showed wear, the policy would cover replacement. That's not the kind of risk sharing for which insurance was intended. And certainly not the kind of coverage that people would buy if you gave them the money to purchase insurance.

My employer (approximately 100 employees) has had a CDHP/HSA plan in effect for over 3 years. Our rate increases, including the one for our fourth year, are equal to ⅓ of the average increase for our region. Our most critically ill person (averaging about $80,000 per year in claims) was happier with her HSA coverage than with the high option PPO plan we had in place previously—because her out-of-pocket cost for the year was less!

In holding hearings of this type, you might want to include individuals or companies that are on the front line and are experiencing how HSAs are working. Instead you include individuals who are already biased toward a government-based solution. What does a hearing mean to you—it certainly looks like you were trying to get people together to come to the conclusion you wanted to come to in the first place.

Statement of Melodee S. Webb

Dear Chairman Stark and Ranking Member Camp,

Rockwell Collins is submitting this information for the record as part of the 5/14/08 Health—Hearing on Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift.

For over 70 years, Rockwell Collins (NYSE: COL) has been recognized as a leader in the design, production, and support of communication and aviation electronics aerospace and defense customers worldwide. **The company has 20,000 employees worldwide (17,000 in the U.S.).**

Rockwell Collins' Value Proposition for People has four broad initiatives—Diversity, Talent Management, Leadership Development and Flexible Benefits Choices. Flexible Benefits Choices was developed to provide employees with a basic level of

company-paid benefits coverage and choices to fit the needs of individual employees and their families. "My Health While Working," a component of our benefits offerings, is segmented into medical, prescription drugs, dental, vision and wellness benefits. When we were rethinking the design of our health plans in 2004 to allow for more choices among the plans being offered, the newly-passed legislation allowing for broad application of Health Saving Accounts presented an opportunity to design a new high deductible health plan with significant flexibility for plan participants.

To help our employees make informed choices, we provide comprehensive communications to explain their benefits choices. We have specialized modeling tools that help employees to understand what health plan works best for them and their families. We also provide paycheck modeling to show the impact of pre-tax contributions to our 401(k) and the HSA. Rockwell Collins' introduced a comprehensive wellness program in 2007 with financial encouragement for participation. We have also enhanced the wellness features in our health plans such as waiving co-payments for preventive care. Preventive prescriptions are not subject to the deductible in our HDHP.

Because we designed our program to recognize differences in income levels (with our pay-related features), do not charge a premium for our high-deductible plan and supplied comprehensive, easy to understand information and planning tools, we have experienced strong enrollment since the first year the plan was offered and it has continued to grow. This was not a full replacement so employees continue to have access to a traditional medical plan if that is their preference. Our program changes since 2005 have resulted in improved scores in our annual employee attitude survey. The decisionmaking and forecasting tools, plan design components, and cost/benefits comparisons were key factors employees understanding whether the high deductible plan and HSA or a more traditional medical plan were right for them.

Our employees are benefiting from these plans and the efficient manner in which they can be administered—with appropriate checks and balances but not undue oversight. Restricting these plan options or adding unnecessary processing burdens could make these plans less attractive to participants. It is important to recognize individual circumstances and that there are no simple answers that will serve everyone.

The attachment provides some details about our HSA participation. If you have any questions, do not hesitate to contact me.

Sincerely,

Melodee S. Webb

ATTACHMENT

Rockwell Collins' High Deductible Health Plan (HDHP), "My PPO Plus"

Background:

- The monthly premium is zero (compared to single and family monthly contributions of $73 and $203, respectively, for our traditional EPO Plan coverage).
- The deductibles and out-of-pocket maximums are pay-related (those who earn more, pay more for care) as shown on the chart below.
- 4,910 employees are enrolled in the HDHP out of 12,900 non-union health plan participants (38%). In recent negotiations, we agreed to add the HDHP as a choice in 2009 for unionized employees.
- Modeling tools are available to help employees make informed choices based on their personal medical costs.
- Considerable communications are provided each year about plan features.
- 71% of those enrolled in the High Deductible Health Plan are contributing to an HSA via payroll deduction (for single coverage 57% contribute and for family coverage 81% contribute). There could be even higher participation since individuals can choose to contribute directly to a personal account at many financial institutions and not use our payroll deduction feature.
- Those who contribute to the HSA appear to cover their annual plan deductible.

The following data relates to enrollment in the HDHP for 2008:

Annual Base Salary	Coverage	Annual HDHP Deductible	# Participants	With HSA	Without HSA*	Average Annual HSA Contribution
<$50,000	Single	$1,500	597	289	308	$1,389
	Family	$2,500	649	500	149	$2,668
$50,001 to $75,000	Single	$1,500	1063	616	447	$1,454
	Family	$3,000	960	757	183	$3,133
$75,001 to $100,000	Single	$2,000	301	197	104	$1,981
	Family	$4,000	693	581	112	$3,904
>$100,000	Single	$2,500	128	83	45	$2,280
	Family	$5,000	529	451	78	$4,558

*Others could be contributing directly to an HSA and not use payroll deduction.

Statement of National Business Group on Health

The National Business Group on Health (The Business Group) commends the Congress for creating Health Savings Accounts (HSAs) under the Medicare Modernization Act of 2003 and thanks the Committee for the opportunity to submit this statement for the record. The Business Group, representing over 300 large employers that provide health care coverage to more than 55 million U.S. employees, retirees and their families, is the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues. Business Group members are primarily Fortune 500 and large public sector employers, with 63 members in the Fortune 100.

A Solution in Search of a Problem? Is HSA Substantiation Necessary?

As health care costs escalate and consumers become more engaged, the Business Group supports expanding the flexibility and value of HSAs and opposes increasing the administrative cost and paperwork burden for employers and employees. HSAs encourage smart, cost-effective health care spending and provide people with a potential retiree health savings vehicle. The Business Group recommends that the Committee further analyze the data on the number of HSA accountholders reporting their non-medical expenditures as taxable income before considering imposing unnecessary new administrative burdens on HSA trustees and accountholders. The vast majority of HSA distributions are made for qualified health care purchases. During the previous Ways and Means Committee markup of H.R. 5719, the Taxpayer Assistance and Simplification Act of 2008, the Treasury Department presented preliminary information that a significant number of taxpayers with HSAs who also took distributions for non-qualified medical expenses were reporting their non-health care distributions as taxable. Furthermore, a significant portion of unsubstantiated distributions paid to non-health care merchants are likely to be valid health care purchases from merchants such as grocery stores, discount retailers and other merchants who sell health care products. Accordingly, a substantiation reporting requirement may be unnecessary and raise the cost of HSAs, decreasing their convenience for employees and also raising accountholders' health care costs.

The April 2008 Government Accountability Office (GAO) Report

While the GAO did receive estimates of the number of lives covered by HSA-eligible health plans from 2004 through 2007 from America's Health Insurance Plans (AHIP), the GAO report only analyzed 2004 and 2005 tax filer data from the Internal Revenue Service (IRS) to estimate the number of individuals who reported HSA activity in those years. Thus, the report only utilized tax data from a year when the number of HSA policyholders was one-sixth its current level. Specifically, the report found:

- 2005 HSA contributions totaled $754 million, while withdrawals were only $366 million. This statistic reveals that people are saving HSA funds as intended—to pay for long-term and catastrophic health care expenses.

- GAO cited various employer surveys that employers often contribute $600–800 annually to their employees' HSAs to pay for health care expenses.
- GAO found that, on average, people with HSAs in 2005 tended to have higher annual incomes—averaging $139,000—than the general population of tax-filers, at $59,000. However, a 2006 study by the online HSA sales website, Ehealthinsurance, found that 45 percent of people in HSA-eligible plans had incomes below $50,000 and that **41 percent of HSA purchasers had not previously had health insurance coverage in the prior 6 months**. Another Internet survey in 2005 by the Employee Benefit Research Institute (EBRI) found that 33 percent of people who had opened HSA accounts had incomes of less than $50,000.

HSAs Are Expanding Health Care Coverage and Growing with Small Businesses

Following submission of the GAO report, AHIP released its annual "census" of HSA enrollment, showing 6.1 million enrollees in January; **almost double** the enrollment from 2 years ago. Specifically, the growth in HSA-eligible plans is concentrated among small businesses. Over the last year, the fastest growing market for HSA/High-Deductible Health Plan (HDHP) products was small-group coverage, rising from approximately 25 percent to 30 percent of overall HSA/HDHP enrollment.

Large Employer Examples of the Success of HSAs/Consumer-Directed Health Plans (CDHPs)

The table that follows provides some successful workplace examples of employer-sponsored HSAs among Business Group members.

Company Name	Plan Description	Results
Bank of America [1] (500,000 eligible)	• HDHP with personal spending account similar to HSA, or HSA • For employees who earn less than $100,000—receive up to $100 per month for health expenses • Employer contributes $600–$1,200 into the account for copayments and other expenses	• Employees can use money for health care in retirement • Allow employees to have more control over their own dollars
Financial Services Employer	• HDHP/HSA • Provide health care "navigators" to help employees navigate the health care system • Contributes to HSA in January, June	• 87% enrollment • Two-thirds of employees who participate in HDHP contribute to HSA
General Motors Corp.[2]	• HDHP/HSA	• Increased drug generic utilization rate by 9%, to 65%
Owens Corning [3]	• HDHP/HSA or HRA • Employer contributes $750 per employee, $1,500 per family • $50 incentive to participate in health risk assessment • $40 non-smoker discount	• 300+ employee have quit smoking • Addition of more disease management programs
Pitney Bowes [4] (18,000 eligible)	• HDHP/HSA • On-site health clinics that provide preventive services, like screenings and immunizations • 100% coverage for preventive care	• 20% enrollment
The Kroger Co.[5] (70,000 eligible)	• HDHP/HSA • Preventive drugs are covered outside of the deductible • Employer contributes half of deductible in early January • Matches employee contributions up to $500 for individuals, $1,000 for families	• 23% enrollment, up from 4.6% in 2006

Company Name	Plan Description	Results
Towers Perrin [6]	• HDHP/HSA • $2,850 deductible • 100% coverage after deductible • $500 per person for preventive care • Employees earning less than $50,000 receive $720 contribution from company decreases as salary increases • $120 per person credit for employees/spouses who complete a health risk assessment and engage in health coaching	• 62% enrollment
Wendy's [7] (20,000 eligible)	• HDHP/HSA • 100% coverage for preventive care • Employer contribution covers 60% of deductible	• 70–72% enrollment • 61% generic drug utilization rate • No increase in employee premiums for the past 4 years • 2.5 employees per 1,000 had a colonoscopy—compared to UnitedHealth's average of 1.4 • 38% of employees had a physical, up from 20% in 2004

[1] Atlantic Information Services. (2008, April 25). Bank of America to offer employees health care accounts for expenses. *Inside Consumer-Directed Care, 6*(8).

[2] Atlantic Information Services. (2007, December 21). Generic rx usage reaches 65% under General Motors' cdh plan. *Inside Consumer-Directed Care, 5*(24).

[3] Robbins, M. (2008, April 1). Employers get on the health care superhighway with next generations HSA programs. *Employee Benefit News*, retrieved from ebn.benefitnews.com.

[4] Atlantic Information Services. (2008, May 9). Pitney Bowes account-based plans deliver health and consumerism. *Inside Consumer-Directed Care, 6*(9).

[5] Atlantic Information Services. (2007, January 26). CDH pioneers target behavior among chronic, healthy enrollees. *Inside Consumer-Directed Care, 5*(2).

[6] Atlantic Information Services. (2007, June 8). From burger chains to municipalities, cdh helps employers cut costs, improve health. *Inside Consumer-Directed Care, 5*(11).

[7] Atlantic Information Services. (2007, February 9). Wendy's 'beefs up' preventive care incentives. *Inside Consumer-Directed Care, 5*(3).

Employer-Sponsored HSA/HDHP/CDHPs Provide Evidence of Improved Quality

Preventive Care

A July 2007 survey by AHIP of 36 insurance companies found that nearly all group HSA/HDHP policies and more than half of individual policies cover preventive services regardless of whether the deductible has been met. Specifically:

- 99% of HSA/HDHP policies purchased in the large group market, and 96% in the small group market, provided this coverage.
- In the individual market, 59% of HSA/HDHP policies covered preventive care outside of the deductible.
- Approximately three-quarters (76%) of HSA/HDHP policies cover preventive services without any coinsurance or copayment for covered preventive services.

The 2007 Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Annual Survey found that most employees and their families with HSA/HDHP coverage can get annual examinations, immunizations and screenings without a deductible. Most employers pay first dollar coverage, while others require a small copay or coinsurance. Specifically, the survey found that:

- 88% of employees in CDHP/Health Reimbursement Arrangements (HRA) have access to preventive benefits with no deductible; while 86% of employees with HSAs can access preventive care without a deductible.

Wellness

The Blue Cross Blue Shield Association's 2007 CDHP member experience survey reports that consumers in CDHPs are more engaged than their non-CDHP counterparts in wellness programs, including:

- Smoking cessation—20% vs. 6%;
- Stress management—22% vs. 6%;
- Nutrition/diet program—27% vs. 12; and
- Exercise program—29% vs. 12%.

Treatment Adherence

An April 2007 UnitedHealth Group study found that CDHP enrollees with a chronic illness abide by their treatment regimen at the same rates comparable to, or even better than, enrollees in more traditional plans.

- **Diabetes:** CDHP enrollees were 16% more likely to receive HbA1c tests than members in traditional plans.
- **Coronary Artery Disease (CAD):** CDHP enrollees were 22% more likely to have lipid tests, and were equally likely to see a doctor.
- **Congestive Heart Failure (CHF):** CDHP enrollees were 6% more likely to use ACE inhibitor medications.

Urgent Care

The March 2007 Journal of the American Medical Association examined the effect of CDHPs on emergency room usage because urgent care represents a large portion of today's health care costs, it was important to examine whether enrollees (1) were getting needed care, and (2) were going to the emergency room for symptoms that could be treated at much less expense by a primary care physician (PCP).

- Hospitalizations for patients whose symptoms could be treated by a PCP declined by 29.6% in the HDHP group compared to the control group.
- For the HDHP group, the odds of increasing emergency room utilization after hitting the deductible were no greater in comparison to utilization below the deductible.

Increased Use of Provider and Other Health Information

AHIP's January 2007 "census" found that HSA/HDHPs encourage enrollees to use available resources to aid them in making health care choices on the basis of quality and cost; and, in addition, encourage them to use tools to become healthier individuals.

- 86% of HSA/HDHPs provide hospital-specific quality data; 50% provide physician-specific quality data.
- 88% of HSA/HDHPs make cost information (negotiated rates, drug prices) available to plan members.
- 72% of HSA/HDHPs provide personal health records (PHRs).

The 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey also reports that individuals with CDHPs tend to use consumer health information at higher rates than those in more traditional plans, including:

- Requesting a generic drug substitution;
- Talking to a doctor about treatment and options;
- Checking the price of a service before getting care;
- Participating in wellness programs; and
- Using online cost tracking tools.

Employee Satisfaction

- A 2005 study by Fidelity Investments found that re-enrollment rates for CDHPs reached 95%—the highest of any plan type.
- A 2005 GAO report found that enrollees from the American Postal Workers Union rated CDHPs higher in terms of overall plan performance, compared to other plan enrollees.
- A 2006 Blue Cross Blue Shield Association CDHP member experience survey found that 73% of CDHP enrollees said they are likely or very likely to renew their current health coverage for the following year.

CDHPs Cover Every Age Group

A 2007 EBRI/Commonwealth Fund consumerism in health care survey found that CDHP enrollees cover every age group fairly well:

- 20% between ages 21–34;
- 31% between ages 35–44;
- 30% between ages 45–54; and
- 19% between ages 55–64.

Again, the Business Group appreciates the opportunity to submit this statement for the record. We look forward to working with the Congress and the Members of this Committee to expand the value and increase the flexibility of both HSAs and CDHPs and to improve the effectiveness and efficiency of health care.

Statement of Ross Schriftman

Dear Members of the Committee,

Below is my testimony to a hearing of the PA House Insurance Committee a few years ago. It demonstrates the value of Health Savings Accounts for low- and middle-income people. Unfortunately, I have come to the conclusion that Members of the Committee have been blinded by their opposition to the HSA Concept so much so that they have failed to do the math and realize that the more higher-income people take up HSAs the greater Federal revenue will result.

In fact, many wealthy people whose businesses provide health insurance are more interested in keeping their tax favored expensive plans. It is virtually impossible to get a bigger tax break with a high deductible plan and an employer HSA contribution than it is to keep the current plan.

The greatest beneficiaries of these programs are actually lower- and middle-income workers. The plans are almost always designed with first-dollar benefits for preventive services, coupled with wellness programs. People with chronic conditions also benefit more than they do with co-pay plans that slowly bleed their finances and cost them more in premiums.

I believe certain Members of Congress are afraid that the Health Savings plans will become very popular and then there would be less interest among the American people for a national government-run health care financing system.

May I also remind the Committee that the biggest government program, Medicare has a high deductible health plan with a $1,024 deductible for each hospital benefit period. That is why so many people buy private insurance to fill the gaps.

It is important to note, that unlike Medicare, Medicaid and other government programs, no government unit is making any contributions to Health Savings Account. Contributions are made by individuals and businesses. This is our money. Not yours. All the government is doing is giving us a deduction for the contribution and not taxing the interest. We are accumulating money because we know that programs like Medicare will not be there in its current form in 10 years when we need it. Please let us accumulate our own money.

It is our responsibility to report distributions on our tax returns whether they are qualified 213d expenses or not. You do not have a right to be looking at my day-to-day disbursements from my account because it is no different than my regular checking account. You are stepping over the line of constitutionality.

I urge the Committee to take testimony from individuals and businesses at all income levels and get their input before any efforts are made to take away this valuable benefit. You should be encouraging people to put money aside, not forcing them back into expensive plans.

If you really want to do something useful, look at the $70 billion reported by one study of this year's waste and fraud in Medicare. That is a far more serious problem than one company without solid evidence reporting "misuse" of accounts when in fact people can take out money for whatever they want. They just have to report as taxable amounts that are not for medical purposes.

Thank you,

Ross Schriftman

Health Savings Accounts will help those who need it the most

By Ross Schriftman, RHU, LUTCF, CBC, MSAA

The recently enacted "Medicare Prescription" legislation contains one unrelated provision that will go far in changing the way health care is funded in our nation. Health Savings Accounts (HSAs) will now be allowed in combination with a high deductible health insurance policy for most Americans. These policies cost 30% to 50% less than the current type of plans most people have. The significant savings is then contributed by workers, their employers or both into the HSAs. These funds can then be utilized tax free for a wide range of expenses including dental, chiropractic, and therapy services as well as out of pocket expenses not covered by the high deductible policy. Even certain long term care insurance policy premiums can be paid out of these accounts tax free. The beauty of the HSA concept is that funds can be used tax free for expenses that may or may not normally be covered by insurance and done so at the direction of the patient. (Please consult your tax advisor.)

Opponents of HSAs claim incorrectly that this type of program will only benefit wealthy and healthy people. This is an unhelpful misreading of a valuable program that will give millions of Americans the opportunity to afford quality healthcare.

As far as the tax break, the HSA plans will benefit low- and middle-income workers; not the wealthy. Under the current system, many wealthy business owners have their companies' fund their own premiums tax free and enjoy the benefits tax

free. When adding the premiums for a high deductible policy and the contribution to the HSA, it is virtually impossible to spend more than the current system. (See Exhibit 1.) That is because the HSA contribution can not be higher than the policy deductible. So, wealthy people actually get less of a tax benefit under the HSA program. On the other hand, a low-income worker may be paying a large portion of premiums now. A reduction in premiums and tax free contributions by employers and their workers to an HSA will result in tremendous value for the middle- and low-income employees. (See Exhibit 2.)

Under our current system for privately insured patients, most dollars for health care run through the hands of insurance companies and then are returned in the form of benefits. Administrative costs of processing these claims come out of the premiums. Dramatic rate increases in the last several years are the result of high plan usage and higher costs per service due to regulations, litigation and defensive medicine.

In a sense, there is a perfect storm in our health care system. More employers, especially small businesses, are shifting significant amounts of the premiums to their workers or raising deductibles and co-pays. If workers' premiums are dramatically cut under the new HSA plans, these employees benefit directly. The opportunity for small businesses to grow and hire more workers also increases resulting in a much better economic climate for all of us.

The new law also allows flexibility. Businesses can fully fund the premium for workers, fully fund the HSA contributions or create innovative sharing arrangements to meet specific needs of their employees. This allows a business to better direct the dollars that they and their workers have available for health care.

Finally, it is absolutely untrue that sicker workers are at a disadvantage with these new programs. Under the current system, not only is the worker paying larger premiums and higher co-pays and deductibles every year, but those out-of-pocket expenses can really add up. According to benefit consulting firm Hewitt Associates, the average out of pocket costs including co-pays and other charges doubled in the last 5 years to $2,126. And that was only for large companies. As an example, suppose someone goes to a specialist twice a month and has a $20 co-pay for the service. That is $480 out-of-pocket during the year just to see the specialist. This person could have an HSA program, see a reduction in his or her premiums and utilize the HSA tax free for those doctor visits. If the employer were fully funding the HSA, then the result could be no out-of-pocket expenses for the worker.

I predict that as time goes by more people will recognize the valuable tool that they now have and begin to take control over their own health care spending decisions. They will reduce their dependence on third party payers for each and every health care need. The result will be lower costs and a patient driven health care system for our country.

Ross Schriftman is an employee benefit specialist with Kistler Tiffany Benefits in Berwyn, PA. He holds the professional degrees of Registered Health Underwriter, Life Underwriters Training Council Fellow, Chartered Benefit Consultant and Medicare Supplement Accredited Advisor. Mr. Schriftman served as the Legislative Chair for the Pennsylvania Association of Health Underwriters and the Associate Chair for Long Term Care of the National Association of Health Underwriters. He teaches insurance courses to other insurance professionals including a course in preparation for the Chartered Benefit Consultant designation.

Health Savings Accounts
Ross Schriftman, RHU, LUTCF, CBC

Exhibit 1. High Income Business Owner with Company-Paid Health Coverage

(Age 40 with Family Coverage)

Current PPO Plan Annual Premium	High Deductible Plan ($3,500 Deductible)	HSA Contribution	Total
$12,720	$4,775	$3,500	$8,275
Outlay (premium and contribution) savings to business by using HSA contribution is $4,445			
Tax Breaks (38.6% marginal rate)			
Current Plan—$4,910			
High Deductible Plan and HSA Contribution—$3,194			
Additional Federal Revenue by using HSA Contribution—$1,716			

Exhibit 2. Benefit to Low- or Middle-Income Worker with HSA Plan with Employer and Employee Each Paying 50% of Premiums and Employer Funding the HSA

(Age 40 with Family Coverage)

Current PPO Plan Annual Premium	High Deductible Plan ($3,500 Deductible)	HSA Contribution	Total
$12,720	$4,775	$3,500	$8,275
Employer's Share	**Employer's Share**	**Employer's Share**	
$6,360 Outlay Savings to Employer	$2,387	$3,500	$5,887 $473
Employee's Share	**Employee's Share**	**Employee's Share**	
$6,360 Outlay Savings to Employee	$2,387	—0—	$2,387 $3,973

Note: Bottom line result is that the employee will save $3,973 in premium AND have $3,500 available for out-of-pocket expenses in the first year alone while the employer still saves $473 in total outlay.

Statement of Terri Buck

Chairman Stark, Mr. Camp, and Members of the Committee:

I read some of the material that was submitted to you regarding HSAs and high deductible health plans and am writing to give my input.

My husband is self employed and I work two part time jobs. Neither of us is eligible for health insurance through an employer. We have a 10-year-old child who we also have to provide for.

We have a high deductible plan with a $10,000 deductible. We have an HSA that we contribute to on occasion, when we can afford it. We are not wealthy or high income. My husband draws a check from his business when he makes enough money to do so. He sets his salary at $500 a week, gross income. If we took a pay check each week his pay would be $26,000 a year. Then, if you consider my income from two part-time jobs at minimum wage you would get a clearer picture about how we live. We have two vehicles (no SUVs). One is a 2004 and the other is a 1997.

We pay $341 a month for the health plan. I called around to the local pharmacies to see who gives the best discount for cash and that is where I go. Our family doctor gives a discount for cash. Our eye doctor gives a discount for cash. Our dentist does not.

Paying for the prescriptions we need monthly (one is $28 a month and the other is $135 a month) and the doctor visits as needed is more cost effective for our low income family than paying for a health insurance policy that would cost $600 or $700 a month with all of its mandates (required by State and Federal laws and regulations).

You have been given an impression that isn't true about those of us that use these products. We are paying our own way. We are NOT wealthy. I am not using anything as a tax shelter. I pay my taxes and hope one day we have enough money to put in the HSA on a regular basis.

I urge you to leave these products alone. They are serving us well as they are. If you mess with them I will not be able to afford them.

I urge you to talk to the people like me that use and depend on these products. We are regular people who don't use it for tax purposes but to cover ourselves in the event we need the insurance coverage. We don't expect anyone to pay our routine expenses through a traditional health plan. We can pay those ourselves and it is cheaper for all.

Thank you for your consideration.

Terri Buck
Burlington, IA

Statement of the Council for Affordable Health Insurance (CAHI)

Mr. Chairman and Members of the Subcommittee,

The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, Health Savings Account and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

We at the Council for Affordable Health Insurance believe that all Americans should have access to affordable health coverage. We also believe that consumer driven health plans offer one of the best options for affordable health insurance.

This testimony will focus on two main points:

1. Consumer Driven Health Plans (including plans involving Health Savings Accounts) are part of a larger movement that is positively transforming health care delivery, utilization and financing in this country.
2. The evidence that suggests HSAs are being used inappropriately is weak.

Consumer Driven Health Plans

As companies have struggled to control the rising cost of health benefits, many have raised deductibles and co-payments, which require employees to pay directly for services without any tax advantage. Other employers have simply stopped providing coverage. In both cases, consumers are responsible for making their own decisions on purchasing a health insurance policy or paying directly for the care they consume. While this certainly increases consumer cost awareness and demand for information that helps stretch their health care dollars, the core of consumerism in health care is associated with HRAs and HSAs, known together as "Consumer Driven Health Plans."

Consumer Driven Health Plans have been around for about six years. They began in June 2002, when the Internal Revenue Service released its first guidance on Health Reimbursement Arrangements (HRAs). Then in December 2003, Congress enacted and the President signed legislation enabling Health Savings Accounts (HSAs) as part of the Medicare Modernization Act. Both programs reduce the amount of services covered by an insurance plan, but supplement the insurance with an account of money that receives the same beneficial tax treatment as the insurance portion of the coverage. Money not spent in one year may be rolled over and used for future expenses.

The two approaches—HRAs and HSAs—are centerpieces of consumer driven health, but they are not the only elements. Other approaches include flexible spending accounts that enable workers to set aside some money to pay directly for the care they need. Other aspects include a renewed focus on patient-centric care services such as personal health records, disease management programs, wellness programs, preventive care, care coordination, and the like.

After 5 years of experience, the evidence clearly shows that:

1. Patient behavior is changing and people are being more cautious about needless use of services.
2. Consumers are more compliant with treatment regimens, especially those with chronic conditions who are high utililizers of services.
3. The rate of increase in health care costs is down substantially for people and groups in these plans.
4. The demand for information, transparent prices and patient-support services is high.
5. The adoption rate in the benefits market continues at a rapid pace.
6. The transformation of service delivery is beginning, though still very formative. Early indicators include the growth of retail clinics, concierge-medicine practices, and medical travel (both domestic and international).

Enrollment Trends

America's Health Insurance Plans (AHIP) is the largest trade association of the insurance industry. Every year since March 2005, it has surveyed its members about HSA enrollment. AHIP found there were 1 million enrolled in HSA programs as of March 2005, 3.2 million in January 2006, and 4.5 million in January 2007.

On April 30, AHIP released its 4th annual survey of enrollment in HSA-qualified health plans. As of January 2008, more than 6.1 million Americans are covered under HSA plans, a 35% increase over last year and almost double the number in 2006. This is an increase of approximately 1.6 million Americans enrolled in an HSA plan since January 2007.

Other key findings from the latest survey include:

- **The majority of the enrollment continues to come from the employer-based group market—**4.6 million Americans with HSA coverage had employer-based coverage; 30% of individuals covered by an HSA plan were in the small group market; 45% were in the large-group market, and the remaining 25% were in the individual market.
- **Small businesses are strongly embracing HSAs—**HSA enrollment in the small group market increased 70% over the past year. Over 1.8 million Americans working for small businesses now have coverage through HSAs.
- **HSAs continue to make health insurance more affordable for the uninsured—**HSA products accounted for 31% of new coverage issued in the small group market and 27% of their new purchases of health insurance in the individual market.

AHIP also found that people enrolled in HSA programs have wide-spread access to preventive services, disease management programs, and information and patient-support tools. The vast majority has access to account information on line (93% of all HSA enrollees), health education information (99%), physician-specific information (97%), hospital-specific quality information (86%), and health care cost information (88%). The companies offer coverage of disease management for diabetes (91%), coronary artery disease (90%), congestive heart failure (89%), and asthma (87%).

More recent surveys find CDHPs have continued to grow rapidly. In 2007, United Benefits Advisors (UBA) surveyed 10,000 employers and found that 56% more companies offered CDHPs in 2007 than in 2006, and 76% more people were enrolled. It also reported that this growth is concentrated in the 25–100 employee group market.

Cost Trends

The growth in enrollment is fueled largely by favorable cost trends. The UBA survey cited above found that the cost of CDHPs went up just 2.7% in 2006, compared to 7.2% for all other health plans. This finding is supported by many other reports:

- Deloitte reports that trend for CDHPs in 2006 was 2.6%, as opposed to 7.4% for HMOs, 7.5% for PPOs, 7.3% for POS, and 6.6% for traditional indemnity coverage.
- Cigna reports an overall trend of 10.3% in 2005, but only 4.8% for its HRA products and minus 1.2% for its HSAs.
- An updated report from Cigna (October 2007) found that medical trend for its CDHP enrollees was less than half the trend for its PPO and HMO enrollees, even though out-of-pocket costs were similar for the two groups.
- Minneapolis-based HealthPartners reported in October 2007, that medical costs for its CDHP enrollees was 4.4% lower than for people in traditional coverage, even after adjusting for health status.
- In the non-group market eHealthInsurance reported that premium costs for HSAs dropped 17% for individuals and 4.6% for families from 2004 to 2005.
- Aetna reported on 4 years of experience with HRAs and found a 1% annual increase for full-replacement employers and 6.7% for employers that offered them as an option.

Clearly something important is happening here. The same phenomenon is being reported by many different and independent sources. The cause is not a mystery. It comes from very favorable utilization changes.

Utilization Trends

Enrollment is going up and costs are stabilizing because Consumer Driven Health Plans are doing exactly what they promised to do—change patient behavior.

UnitedHealth Group has recently reported that people in CDHPs are:

- Far more likely to see a doctor for diabetes (73% vs. 54%) and 16% more likely to receive HbA1c tests if they have diabetes.
- 22% more likely to have lipid tests if they have coronary artery disease.
- 6% more likely to use ACE inhibitors, 41% more likely to get creatinine tests and 26% more likely to receive potassium tests if they have congestive heart failure.
- 16% more likely to get cervical and prostate screening
- 10% more likely to get cholesterol screening
- Similar on all other measures.

The Blue Cross Blue Shield Association reported in 2006 that people with HSAs are more likely to—

- Use nurse hotlines (10% v 6%).
- Participate in wellness programs (20% v 8%).

- Use provider information tools (39% v 10%).
- Use Rx cost and comparison tools (42% v 19%).
- Use website based coverage information (53% v 32%).

A more recent report from the Blue Cross Blue Shield Association confirms these findings. They show us that CDHPs empower consumers and help them become more engaged in their health care decisions.

Some of the information provided includes the following:

- HSA enrollees are much more likely to research health information, including:
  - Doctor quality: 20% of HSA enrollees; 14% of non-CDHP enrollees.
  - Doctor costs: 14% HSAs; 4% non-CDHPs.
  - Hospital quality: 12% HSAs; 7% non-CDHPs.
  - Hospital costs: 10% HSAs; 3% non-CDHPs.
  - Insurance information: 25% HSAs; 17% non-CDHPs.
- HSA enrollees are much more likely to plan and save for future health care expenses:
  - Track health care expenses: 63% of HSAs; 43% of non-CDHPs.
  - Estimate future health care expenses: 38% of HSAs; 19% of non-CDHPs.
  - Save for future health care expenses: 47% of HSAs; 18% of non-CDHPs.
- HSA enrollees are much more likely to participate in wellness programs:
  - Smoking Cessation: 20% of HSAs; 6% of non CDHPs.
  - Stress Management: 22% of HSAs; 8% of non-CDHPs.
  - Nutrition Programs: 27% of HSAs; 12% of non-CDHPs.
  - Exercise Programs: 29% of HSAs; 12% of non-CDHPs.
- HSA enrollees are no more likely to forego care due to cost:
  - Did Not Go To Doctor: 18% of HSAs; 18% of non-CDHPs.
  - Delayed Treatment: 17% of HSAs; 17% of non-CDHPs.
  - Delayed Prescription: 15% of HSAs; 15% of non-CDHPs.

Cigna studied the experience of 38,211 "Choice Fund" (including both HSAs and HRAs) enrollees and compared it to the experience of 231,680 people enrolled in its PPO and HMO products. It found the Choice Fund enrollees had 11% lower costs for pharmaceuticals, 24% lower for inpatient care, and 10.7% lower for outpatient care. It found these savings were not the result of healthier enrollment. It also found that Choice Fund enrollees were 12% more likely to use preventive care and that, "Choice Fund" members are more compliant with medications that manage ongoing conditions, and more discerning in their use of medications with over-the-counter alternatives.

These findings were confirmed by Cigna in October 2007, in a followup report that said, "First year member preventive visits increased and second-year member visits remained significantly higher than those among traditional plan members (and) use of maintenance medications that support chronic conditions increased while costs decreased."

McKinsey & Company reports that people in CD health programs are:

- More likely to comply with treatments than people in traditional plans (36% vs. 27% for diabetes, and 51% vs. 31% for HBP).
- 25% more likely to engage in healthy behaviors and 30% more likely to get an annual physical.

A study in the *Journal of the American Medical Association* (March 14, 2007) found that people in CDHPs have 10% fewer ER visits overall and 25% fewer repeat visits, almost entirely for non-severe conditions: "Our study showed that for most members, the high-deductible plan seemed to work as intended," said Frank Wharam, MD, MPH, research fellow in the Department of Ambulatory Care and Prevention at the Harvard Medical School and the study's lead author. "Patients went to the emergency room less frequently for non-emergency conditions."

We are in the midst of a transformation in American health care. Not everything about consumer directed health care will succeed, but the overwhelming preponderance of the evidence says it is working exactly as it was intended to work. Policymakers who ignore or deny this development are missing out on the most significant change in health care in recent times.

HSAs Are Not Tax Shelters for the Wealthy

A recent report by the Government Accountability Office (GAO) has been used by some to suggest that HSAs are merely tax shelters for wealthy individuals. This conclusion is based on two findings from the report:

- The average adjusted gross income was about $139,000 for Health Savings Accounts enrollees compared to $57,000 for all other filers **in 2005**.
- The total value of all Health Savings Accounts contributions reported to the IRS **in 2005** was about twice that of withdrawals—$754 million compared to $366 million—suggesting an interest in it more as a tax shelter than a vehicle to obtain needed health care or supplement inadequate coverage.

Furthermore, GAO's findings are being used to justify support for legislation passed earlier this month in the House (H.R. 5719) that would require HSA enrollees to substantiate that HSA withdrawals were used for allowable medical expenses.

It is important to realize that the data used by the GAO was from 2005—only the second year of the HSA program. According to the AHIP survey for that year, only 1 million Americans were even covered by HSAs, over half of which were covered by HSAs in the individual (non-group) market. Unfortunately, GAO did not conduct any further analysis of these individuals to determine whether these "early adopters" of HSAs may have been better educated people buying policies on their own, including many self-employed people.

Still, GAO does not present a strong case for HSAs being "tax shelters for wealthy Americans." For example, the average contribution to an HSA in 2005 was $2,800 for taxpayers with income above $100,000 vs. $1,400 for those with income under $30,000. But the average taxpayer with an HSA also made withdrawals—$1,300 for those with income above $100,000 vs. $600 for those with income below $30,000. So the net-net is that taxpayers with HSAs with income above $100,000 "sheltered" $1,500 vs. $800 for those with income below $30,000.

Finally, it is not appropriate to compare income for taxpayers with HSAs to the average income for all taxpayers, the latter of which includes individuals who do not have access to HSAs because they are covered by Medicare, Medicaid, Tricare and other programs. A better comparison would be to compare the incomes of individuals with HSAs only to individuals with private health insurance coverage. We hope the Subcommittee will ask the GAO to revise and update its analysis to reflect this fact.

Conclusion

CAHI appreciates the opportunity to submit our statement for the record. HSAs are providing some measure of tax equity to Americans who are individually purchasing health insurance. People are uninsured because they cannot afford to buy health insurance coverage. We believe HSAs help fill that need by helping millions of Americans gain and keep health insurance coverage. We look forward to working with Congress and Members of this Committee to preserve and expand this vital health care option.